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.C. 8	certificate
'n	death
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2 2	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2
-	S.
ď	HOSPITAL
	물

	1. DECEDENT'S NAME (First, Middle	, Lest)	01 10		ICATE OF			REG. N			3. TIME OF DEATH			
	B-0-11-0		Blake				Moi	34 2	9	47	4 . 55 P			
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DAT	TE OF BIRTH		8. BIRTH Countr	IPLACE (State or Foreign ny)			
	9a. FACILITY NAME (If not institution		04	YAS.	DE CITY TOWN	OR LOCATION OF		181			necticut			
CTOR	MANOKIN (ramor				CESS A		و	Se. COUN		erset			
DIRE		COUNTY		10c. CIT	Y, TOWN OR LOCA						10d. INSIDE CITY			
	Maryland 100. STREET AND NUMBER	Somerset				field					1 TYES 2 1 NO			
FUNERAL	3394 Lawsonia	Road			,	of ZIP CODE 2181	7		10g. CITIZ		WHAT COUNTRY?			
S	11. MARITAL STATUS	12. WAS DECEDE	NT EVER IN U.S.	ARMED	13. WAS DE	CENDENT OF HISP	ANIC ORIG	BIN? (Specify Y	ea or No—		- American Indian,			
BY	1 Never Married 2 Married 3 Widowed 4 X Divorced		1 ☐ YES 2. WAR OR DATES	NO		specify Cuben, Maxie S 2 X NO Spec		o Rican, atc.)		Speci	k, White, etc.			
ED E	15. DECEDENT	'S EDUCATION	100	DECEDENTIO	CEDENT'S USUAL OCCUPATION						White			
E	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4 or 5		(Give kind of a	work done during w	nost of working	1	66. KIND OF B	USINESS/INDL	JSTRY				
COMPLET	H.S. Graduate		-	Iomema	ker			Home						
	17. FATHER'S NAME (First, Middle, La	. ,				18. MOTHER'S N								
BE	Charles B. Waller Charlotte Rudd 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number of Burnt Bouth Number Charles Street S													
2	The first transfer of													
	Rev. Thomas W. Blakelock (SON) 3394 Lawsonia Road - Crisfield, MD 21817													
ì	20a. METHOD OF DISPOSITION 1 Burlal 2 X Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, grematory or other place) 20c. LOCATION — City or Town, State													
	21. SIGNATURE OF BAJERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Date of allowing Control of the Co													
	Robert H. Bradshaw, Jr. Bradshaw & Sons Funeral Home 306 W. Main St Crisfield, MD 21817													
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	· Que	use on each II	ine.	cur	ode of dying, au	ch aa ce	ordlec or reep	piratory arre	et,	Approximate interval Between			
ERTIFICATION	disease or condition	a. DUE TO	Use on each II	SEQUENCE OF	not enter the mo	ode of dying, au	ch aa ce	or reel	piratory arre	at,	Approximate interval Between			
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Add Charles

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1	L	5	n	2
Ł	1-3	J	U	4

Physician /Medical **Examiner**

3. Time of Death 4:05 PM

10d. inside City Limits 1 No 2 No

94109

Approximete interval Between Onset end Death

White

4c. County of Death

Funeral

Director

Director

Funeral

þ

Completed

Pages 1 and 2 should be filed within 72 hours efter death with the Men/land neat of Heelih and Mental Hygiene.
ant: if item 27 is marked orber than "naturel", or items 23a or 28e-f show unt; or items 20 or 28e-f show uny or other traumatic event, me Medical Exerting revall be notified at

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner

Physician/Medical

Completed by

Be

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Certification:

edical

permit. Pages Department of Important: If it eny injury or o

physician and s the burial-transit The law requires that the death certificate be executed signed by the et d be deteched for page 2 Aftar this certificate Hospital or Attending Physician: director, efter death completaly filled in by the 24 hours

Division of Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) 2. Date of Deeth APRIL 25. 1997 WILLIAM JAMES BATTIN 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth William Hill Health Care Center Easton Talbot If Under 1 Yeer if Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) 1□XM 2□ F 137-14-6961 Yrs Sept. 2, 1920 Penna Usual Residence of Decedent 10b. County 10c. City, Town or Location Maryland Anne Arundel Annapolis 10e. Street end Number 10a. Citizen of What Country? 10f. Zip Code 25 Wagner St. 21401 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 (∑X'es 2 □ No WW) if Yes, Give Yeer or Detes: Navv 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Meritei Stetua 1 Never Merried 2 Merried WI I 1 Yes 2 No Specify: 3 Widowed 4 Divorced Navy 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry U.S.Naval Academy Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineering 17. Fether's Neme (First, Middle, Last) 18. Mother'a Name (First, Middle, Meiden Sumeme) William J. Battin Jr. Julia A. McCarthy 19e. informant'a Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Joseph H. Battin 2111 Hyde St. #601 Brother San Francisco, Calif. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete Capitol Crematory April 28, 1997 4 □ Donation 5 □ Other (Specify) Dover Delaware 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility Harrison E. Leonard Funeral Home
312 S. Talbot St. St. Michaels, Maryland 21663
Shock, or heart fellure. List only one cause on each line.

Harrison E. Leonard Funeral Home
312 S. Talbot St. St. Michaels, Maryland 21663
Approximete Upper gastrointestinal bleed
Due to (or es e consequenca of): immediate Ceuse (Final diseese or condition resulting in deeth) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of)

Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

obstructive pulmonary

24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Wes an autopsy performed?

1 Tes

26. Piece of Deeth (Check only one)

1 Yes 20 No

25. Wes case referred to medical examiner? 1 Yes 2 No

28e. Date of injury (Month, Day Year) 5 Pending Investigation

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. injury at Work? 28b. Time of 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e, Certifier (Check only one)

27. Menner of Deeth

1 Naturel 2 Accident

3 Suicide

4 Homicide

1 🛣 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) and manner as steted. 2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signeture, and title of certifier

6 Could not be determined

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Suzanne Niemela M.D. 606 Dutchmans Lane Easton, Maryland 21601

31. Dete filed (Month, Day, Year) State Registrar

32. Registrer's Signeture

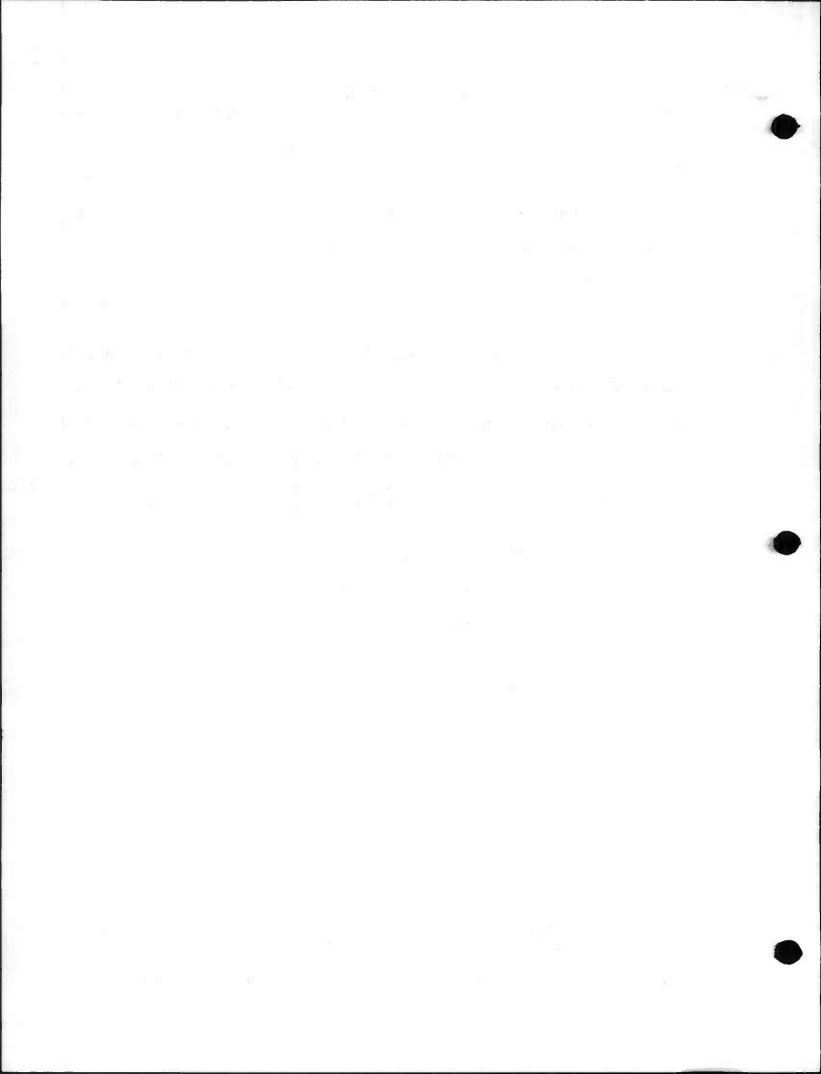
28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify)

within 2 To the To the

State of Maryland / Department of Health and Mental Hygiene 97 | 1,503

						ertificate of	f Death		Reg. No.		14000
Phy	sicia	,	1. Decedent's Name (First, Middle, Las	t) LELAND WHI	TCOME	BECK		2. Date of De Month	ath Day	Year	3. Time of Death
/M	ledica amine	ai	LELAND BECK 4e. Facility Name (If not institution, give				4b. City, Town, or	APRIL Location of Deeth			03:30AM
Fune Direc	_		361-20-0034		s. last birthdey Yrs.	f Under 1 Yea Months Day		8. Dete of Bird	th y, Year) 9,1926	9. Birthpl Count OHI	lace (Stete or Foreig
the Meryland 28a-f show	IN THE		Usual Residence of Decedent 10a. State 10b. County MD TALI		ity, Town or L	ocation XFORD				10	0d. Inside City Limits X☐ Yes 2☐ No
th with the R		٦	10e. Street end Number 5728 PIRATES	COVE ROAD		10f. Zip Code	654		10g. Citizen of V		Iry?
ter dea	EASI STORY OF	Dy Fur	11. Maritai Status 1 Never Married XXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in N Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	U,S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer D Specify:	Specify Yes or No to Rican, etc.)	- 14. Rac Blac Specify	a - America ck, White, e	
Mai yiailia AIAID-0020 d 2 should be filed within 72 hours ef th and Mental Hygiene. 77 is marked other than "natural", or trainmaits went	The Management	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1.2		(Giv	edent's Usuai Occ e kind of work don DO NOT use retii	e during most of wo red)	orking	16b. Kind of Bu		
d 2 should be filed within hand Mental Hygiene. It americal cuter than 7 ls marked other than		o Re C	17. Father's Name (First, Middle, Last) LEO EMIL BECK	-			18. Mother's Na	me (First, Middle, JOSEPH	Meiden Suman	10)	
Heal Heal	200		19a. Informant's Name/Relationship (7 JEANE W. H. BE(20a. Method of Disposition 1 № Buriai 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	CK/ WIFE 20b. Removal from State	5728 Piace of Disp cemetery, cre				FORD, 20c. Location -	MD 2 City or Tov	1654 wn, State
permit. Pages 1 er Department of Hea Important: If Item 2	SUCE.		21. Signature of Funeral Service Licen	<u> </u>	F	22. Name end Add ELLOWS ,	ress of Facility	BEIN &	NEWNAM	FUN	ERAL HO
Physici /Medic Examin	cai		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	e. ATRIAL F13			ying, such as cardia	c or respiratory a	rrest,		Approximete Interval Between Onset end Death
requires that the death certificate be executed een signed by the attending physician end hould be detached for use as the buriel-lransit		medical Examiner	Sequentially list conditions,	b. BONE MARRIED DUE to ((or as e conse or as a conse or as a conse	requence of):	RE				10 9045 142 YRJ
es that the death igned by the atte	hver	y ruysicie	Part II. Other algnificant conditiona co	ntributing to death but not re	suiting In the	underlying cause (given in Part I.		tobacco use co Yes 2□ No	ntribute to	the cause of death
e law requires has been sign	200	indicated in	`					24a. Was perto	an autopsy rmed?	con	ore autopsy findings ailable prior to repletion of cause death?
VICIAN: The la certificate har rector, pece			25. Was cese referred to medical examiner?				28. Place of De	ath (Check only o		10	Yes 25(No
After this funeral di	T. Continu	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	of 28c Inj M 1[ury at ork? ☐ Yes 2 ☐ No		how injury occur	red	
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Sitted		4 Homicide determined	28e. Place of Injury - At he building, etc. (Special				City or Tov			
the Hosp nin 24 ho the Fune	fodiosi		one) 2 Medical Exam	sician: To the best of my kni iner: On the basis of examina and manner stated.	owledge, deal ation and/or Ir	ivestigation, in my	oplnion, death occu	e, and due to the urred et the time,	cause(s) and me date and placa,	nner es sta and due to	ated. the cause(s)
To T	2		29b. Signature end title of certifier	ns ms			7390		29d. Date signed 4 / 2 G	1 (Month, E	Jey, Year)
		;	30. Name and address of person who on NAN BORACHO	ompleted cause of death (Ite	m 23a) (Type NCCLDC Y	Print)	600 N.	Welfe S	ST BOL	TIMOR	E HO

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4504 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death 2. Date of Death **Physician** Bruah Lenore Josephine 24, 1997 APRIL 18:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY if Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 8. Dafe of Birth (Month, Day, Year) Nov • 25 • 1931 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours Yrs. 65 Director Pennsylvania 211-22-5267 Usual Residence of Decaden deeth with the Maryland 7 28a-f show 10a, Stata 10c. City. Town or Location 10b. County 10d. Insida City Limits Florida Polk Winterhaven 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? r than "naturel", or items 23s or the Medical Examiner must be 14500 State Route 545 33881 U.S.A. 11. Marital Status 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indien Bleck, Whife, etc. filed within 72 hours effer 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White If Yas, Giva Yaar or Datas: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grada complated) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed will Dependentment of Heelth and Mental Hygien. Important: if itam 27 is marked other that any injury or other traumatic event, the once. Teacher Private School 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Joseph M. Aubele Josephine E. Stack 19a. Informent's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Mark P. Brugh / Son 313 Overbrook Road Hagerstown, Maryland 21742 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery April 28, 1997 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Douglas A. Fiery Funeral Home 23a Part. Enter the disease, or complications that paused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart fellure. List only one cause on each line. Hagerstown, Maryland 21742 Approximata Intarval Batween Onsat and Death Physician /Medical Immadiata Causa (Final 35 years Myeloid Metaplasia disaasa or condition resulting In death) **Examiner** Examiner physicien end the buriel-transit lew requires that the deeth certificate be executed Sequantially list conditions, if eny, laading to immediate causa. Enfar Undarlying Causa (Disaasa or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai Dua to (or as a consequence of) 950 lor ed by the deteched Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t renal failure 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Ware eutopsy findings available prior to 24e. Was an autopsy performed? coronary artery disease peed complation of causa of death? 1 ¥Yas 2 No 1 Yas 2 No this certificate Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifica director. 25. Was casa rafarrad to medical Be 26. Pleca of Death (Chack only ona) examinar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yas 2 No 1 ■ Inpatiant 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Mannar of Deeth 28b. Tima of 28d. Dascribe how Injury occurred Certification: 28c. Injury at Work? 1 Netural 5 Panding 1 ☐ Yas 2 ☐ No 2 Accident invastigation 6 Could not be determined 3 Suicida 28a. Place of Injury - Af homa, ferm, sfraat, factory, office building, etc. (Specify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 29a. Certifiar (Check only one) Medical 🕮 Certifying Physician: To the best of my knowledge, death occurred at the firme, date end place, and due to the cause(s) end manner as stated. 2 Madical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, deta and place, and due to the causa(s) end manner stated.

29c. Licansa numbar

Rachel McCormick, Johns Hopkins Hospital Baltimore Maryland
21205

APR 281997

Jan Maryland
21205

RES-000

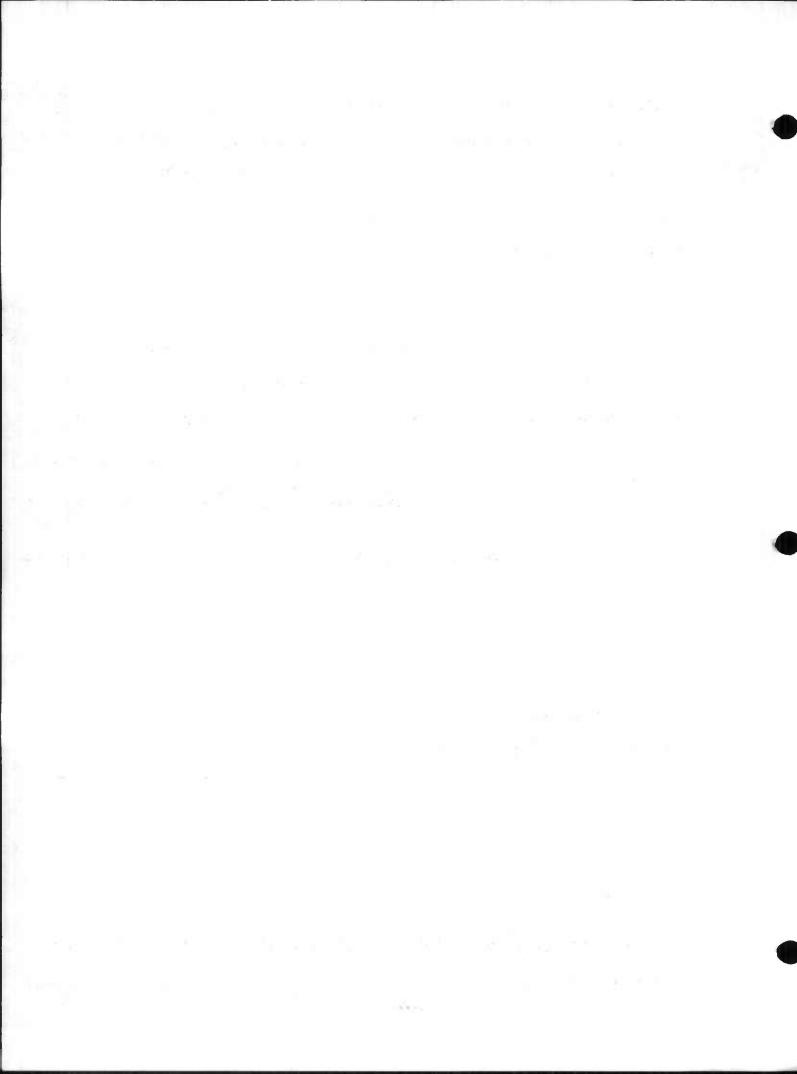
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M.D.

29d. Data signed (Month, Day, Year) April 24, 1997

State Registrar 29b. Signature end titla of certifiar

within 2 To the



1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

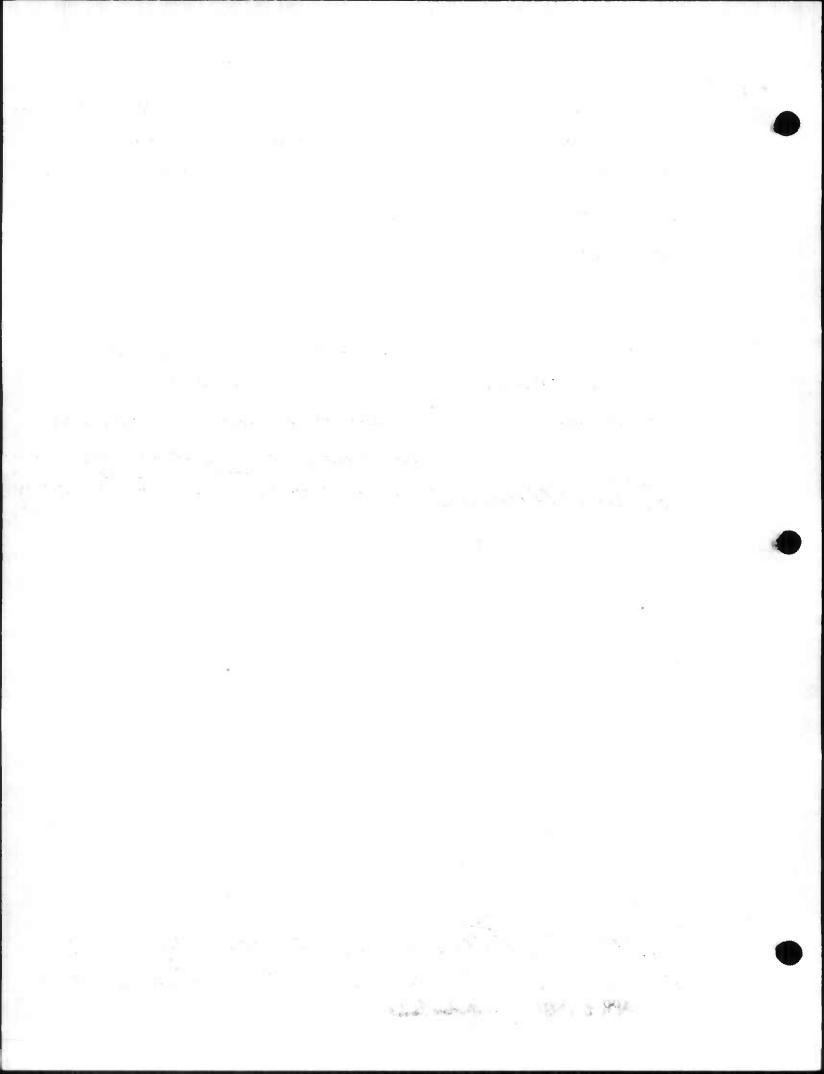
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	1. DECEDENT'S NAME (Firs. MARY A	LICE	BARTO	N							2. DATE OF MONTH APR	DEATH D		YEAR	3. TIME OF DEATH
li	4. SOCIAL SECURITY NUM	BER	5. SEX		n yrs. lest b	(lettle elect)	IF IMPORT	R 1 YEAR	IF UNDER		7. DATE OF				4:15PM м
	186-30-5		1 🗆 M 2 💢 F	9:		YRS.	MONTHS	DAYS	HOURS	MIN.	JUN	ev. Year)		Country	TIELD, MD
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DIRECTOR	RESIDENCE OF DE	CEDENT	S NUKSI	ING (CENI	EK	EM	1115	BUK	J			FRE	DER.	LCK
	10a. STATE	10b. COUNTY					Y, TOWN								10d. INSIDE CITY LIMITS?
	PA	F	RANKLIN			BI	LUE	RID	GE S	SUMM	IIT				1 TES 2 NO
FUNERAL	10e. STREET AND NUMBER							10	f. ZIP COD	E			10g. CITIZI	EN OF WI	HAT COUNTRY?
剪	13639 CR	AWFOR			BOX		(3)		173	214				USA	A
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B√	3X Widowed 4 Div		IF YES, GIVE W										Specify		
		EDENT'S EDU			18a. DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSH							BINESS/INDU	STRY		
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MP			2		POSTAL CLERK							PO	ST O	FFI	CE
COMPLET	17. FATHER'S NAME (First, I			ME (First, Midd											
BE	MAKVIN F. BIRELY ALICE V. MOSER														
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	21. SIGNATUME OF FUNERA	L SERVICE LIC	ENGE				22.	NAME A	ND ADDRE	SS OF FAC	CILITY Gro	ve F	me, Inc		
	James	4.	Douber	Sac	50 S Broad					d ST Waynesboro PA 17					628
	23. PARTA Enter the d ahock, or h	lseases, or c	complications that List only one cau	caused se on ea	the death	h. Do r	ot anter	the mo	da of dy	ing, suci	h aa cardlad	or reapl	ratory arres	et,	Approximata Interval Between
	IMMEDIATE CALLSE (EL	nel													Onset and Death
	disease or condition resulting in death)	→	. Metast	atio	e Bi	lia	ry	Tre	e Ca	ince	r (K)	lats	kius	Tun	nor) 1yr
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CAT	cause. Enter UNDERLY	ING													İ
Ĕ	CAUSE (Disease or injuthat initiated eventa		DUE TO	(OR AS A	CONSEQUE	ENCE OF	ን:								
E	resulting in death) LAS	T .	d												
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PHYSICIAN:	EXAMINER?	O MEDICAL	HOSPITAL:				OTHE	R:							
¥	27. MANNER OF DEATH		1 Inpatient 2 I			Bb, TIM			URY AT	sidence	6 Other (S)				
	Natural 5	Pending	(Month, Di		1	INJ	URY	WC	PRK?	I NO	200. DESCHI	BE HOW I	NJURY OCCU	RED	
ВУ	3 Suitelde	Investigation	26a. PLACE O	F INJURY -	— At home.	, farm, s	treet, fec			110	28f. LOCATIO	N /Street s	nd Number or	Primi Po	rto Mimber
E	_ 0 _	Could not be determined	building,	etc. (Specif	<i>(y)</i>						City or Ti	own, State)	THE THEIR CO	THURST FILE	ute regresse,
1 1	29a. CERTIFIER	IFYINO PHYSI	CIAN: To the beat of	my knowle	dge, death	occurre	d at the t	lme, date	and place	and due	to the course!	a) and man	nor so stated		
COMPLET											and menner as stated.				
BE	286. STOMATURE AND TITLE	OF CENTIFIER		1/7	_					NSE NUM	IBER				Month, Day, Year)
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-	Bonita J.		el-Porti					Ave	Fmr	nitel	nıro	MD	21717		
-	31. DATE FILED MANY, DAY	X 1007	A. DEGISTA	R'S SIGNA	T'AL.	4			*****		501.6	. 110	-1/1/		
	AFR \$	DATE FILED PRINTS 8 897													

State of Maryland / Department of Health and Mental Hygiene

14506 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month April 27° 1997 12:30a.m. Anabel Mamie BARNES /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 7811 Spout Spring Road Frederick Frederick Hours Min. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Days 1 □ M 2 🗓 F 77 Yrs 219-05-2968 Director Oct. 3,1919 Pennsylvania Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Maryland Washington Leitersburg 1 Yes 2X No Director 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 21449 Leiter Street 21740 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0020 white 1 ☐ Yes 2 No Specify: Completed by 3K Widowed 4 □ Divorced Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natur 1ry or other traumatic event, to a Modical 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 0-12 homemaker own home Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be Jacob Gardenhour Schultz 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mr. Michael Barnes 905 Potomac Avenue, Hagerstown, Maryland 21742 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Locetion - City or Town, Stete 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State Department of important: If any Injury or April 30,1997 Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Rest Haven Cemetery Minnich Funeral Home 21. Signeture of Furnical Service Licenses 22. Name end Address of Fecility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Physician/Medicai Examiner The law requires that the death certificate be executed the burial-transit Sequentielly-list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest P.O. Box 68760, Due to (or es e consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ director, page 2 should be 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? After this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Plece of Deeth (Check only ope) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 Yes 2[]No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA filled in by the funeral 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending Investigation 1 Neturel To the Hospital or Attendin. within 24 hours efter death. To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. Medicai 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end eddress of person who completed cause (Item 23a) (Type, Print) State Registrar

DHMH 16 Rev 6/95



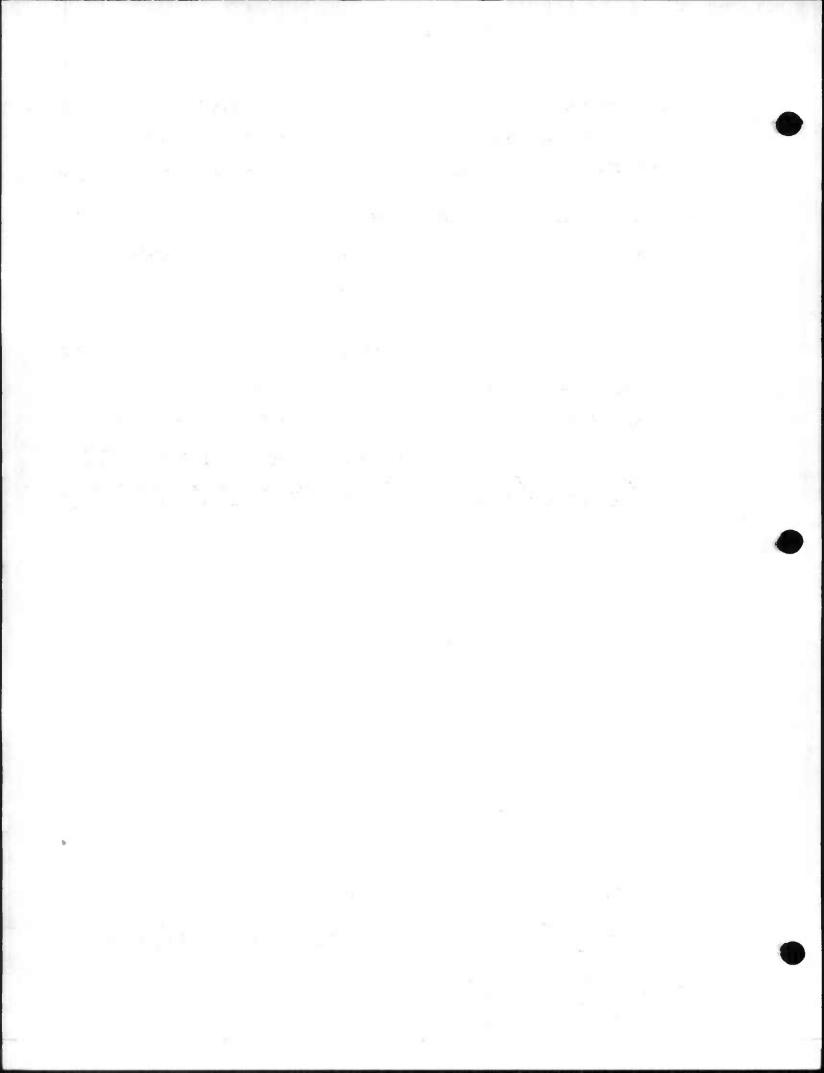
State of Maryland / Department of Health and Mental Hygiene 16507 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Deeth April 10, Day 1997 **Physician** Mary Catherine Cosden 8:00 p.m. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Magnolia Hall Nursing Home Chestertown Kent Hours Min. 8. Data of Birth (Month, Pay, May 15, 5. Social Sacurity Numbar If Undar 1 Yaar Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) Funeral 1 M ACK Days 219-07-6724 85 Yrs. Director Maryland Usuai Rasidanca of Dacedant filed within 72 hours efter death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show Items 23s or 28s-f shov instrings be notified at XXYas 2 No Director Chestertown Maryland Kent 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 21620 U.S.A. 200 Morgnec Road Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status traumatic event, the Medical Examiner 1 Navar Married 2 Married 21215-0020 6 1 Yes 2 XNo Specify: Be Completed by Specify: 3 Widowed 4 □ Divorced White natural 15. Dacedant's Education 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elamantary/Secondary (0-12) Collega (1-4or 5+) 10 Homemaker Domestic/Own Home Baltimore, Maryland 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health end Mental Edward Sylvester Cronshaw Katie E. Price 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Paul Cosden/Son 316 Hazeltine Drive, DeBary, Florida 32713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Sudlersville Cemetery/April 13, 1997 Sudlersville, 21. Signature of Ednaral Sarvice Licansaa 22. Nama and Addrass of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23e. Part 1. Enter trif disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiec or respiratory arrest,

Approximate

App Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) **Examiner** Due to The law requires that the death certificate be executed the buriel-transit Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disasas or injury that initiated avents rasulting in death) Last end Division of Vital Records, P.O. Box 68760, ettending physician Physician/Medical Due to (or as a consequence of): Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 2000 3 Probably 4 Unknown 1 Yes þ Completed 24b. Wara autopsy tindings available prior to completion of ceusa of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Wes casa raferred to medicel axaminar? 26. Placa of Death (Check only one) Other: Nursing Homa 5 - Rasidance 8 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatiant 3 DOA After this filled in by the funeral 27. Menner of Daati 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 1 Naturel 5 Panding Invastigation deeth. 1 Yas 2 No 2. Accidant within 24 hours efter deet To the Funeral Director: completely filled in by the 6 Could not be 3 Suicida 28a. Place of Injury - At homa, farm, straet, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 ☐ Homicide Hospital edical (Certifying Phyaictan: To the best of my knowledge, deeth occurred at the time, deta and place, and due to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, deta and place, and due to the ceusa(s) and manner stated. 29a, Certifian 29b. Signeture and title of certifian 29c. Licansa number 29d. Data signad (Month, Day, Year) 3 30 Nema end eddress of person who completed as sa of death (Item 23a) (Typa, Print) RY ne 31. Data filad (Month. strar's Signatura Julia Davidson Year) State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

91

14508

	_					Cel	runcate	OI I	Death		F	leg. No.			000
Physiciar /Medica	ıl .		SIMPKIN			CARE	Y				2. Data of Dea Month APRIL	28 1	1997	6:	ma of Death
Examine	r	4a. Facility Nama (If not institution BERLIN NURSING			TATION	CEN	TER	4	BERL		ocation of Death		ty of Death ESTER		
Funeral Director		5. Social Security Number 216-46-0443	6. Sex 1 □ M 2 2 F		(In yes. last i	Yrs.	If Under 1 Months (Year Days	If Under 2 Hours	Min.	8. Date of Birth Month, Day 10/08/1	912	9. Birthy GEOR	GIA	tate or Foreig
the Maryland 28a-f show notified at		Usual Residence of Decedent 10a. State 10b. County MARYLAND WORCES	STER		10c. City, To		cation KE CIT	Υ							de City Limits 'Yes 2□No
5 52 2	al Director	10e. Street and Number 352 WINTER QUAR	RTERS DR	IVE			10f, Zip Ci	ode 218	51			of What Country?			
ours after death v nat', or thems 23e Examinet must	D.	11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	Armed 1 Ye If Yes,	Forces? s 227N	over in U.S.		Was Deceder f Yes, specify 1 ☐ Yes 2 ☑			in7 (Sp Puerto	ecity Yes or No- Rican, etc.)	ify Yes or No- lcan, etc.) 14. Race- Black, Specify:			in,
d 2 should be filed within 72 hours at the and Mental Hygiene. 7 is marked other than "catural" or traumatic event, the Medical Exams To Re Commission by To Re Commission by 8	ompieted	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade complete		+)	a. Deced (Gl/ve ///a. /			supation 16b. Kind of Business/Industry (red) OWN HOME						
should be filed and Mental Hygi marked other metic event, I	e e	10 HOUSEWIFE OWN HOME 17. Father's Name (First, Middle, Last) FREDERICK W. SIMPKINS HOUSEWIFE OWN HOME 18. Mother's Name (First, Middle, Maidle, M													
	18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)												2185		
permit. Pages 1 ar Department of Hea Important: If Item 2 any injury or other once.															
Certificate be executed and in physician and weeks the buriel-transit as the buriel-transit and	redical Examinies	Immediate Cause (Finel disaasa or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or injury that initiated evants rasulting in death) Last	b	CA	Dua to (or as	e consequa	quence of):		CERU!						al Batween and Death
d by the etter detached for u	riiyarcia	Part II, Other eignificant condition	d	death bu	t not rasulting	in tha ui	ndarlying cau	sa giv	an in Part I.			obacco use c			use of death
The law requires the law requires the law requires the law radio and law radio and law requires the law requires the law requires the law requires the law requirements and law r	inhieren ni										24a. Was a		av cc	/allable	opsy findings orlor to n of causa
Physician: The lattice the trial director, page	2	25. Was casa referred to medical axaminer?	Hospitei:					Oth			1 □ Y	na)		☐ Yes	2No
Iling Affer fune	- -	1 Yas 2 No 27. Manner of Deeth 1 Naturel 5 Pending 2 Accidant Invastig 3 Sulcida 6 Could n	28a. De (Ma	Inpatiar te of Injury onth, Day	Year) 28b	Tima of Injury	M 28c	Injun Worl	442 Nui		ma 5 Rasid	ow Injury occ	urred		Mumba
\$ 5 2 0 O		4 ☐ Homicide datami	Physician: To t	lding, atc.	ry - At homa, . (Specify)	ga, daath	occurred at	tha tin	na, data and	place	28f. Location (S City or Tow and dua to tha	n, State) ausa(s) and n	nannar as s	stated.	
To the Hospi within 24 hou To the Funer completely fil		(Check only 2 Medical E	xeminer: On the	basis of	examination a	and/or inv	vastigation, in	my o	pinion, daati e number 46257	h occuri	red at tha tima, o	lata and place	, and dua t	tha ca	
	-	30. Nema and addrass of person v			eath (Non 24a E 103	314	Print) FRANK	LIN	N AVE.	В	ERLIN N	D 218	811		

State Registrar 31. Data filed (Month, Day, Year) Julia 232, Registras Songeura



State of Maryland / Department of Health and Mental Hygiene 97 11509

						Certificate	of Death		Reg. No.)	14000
			1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath	V	3. Time of Deeth
	Physici /Medi		Matthew		Cream	er, Jr.		April	21 19	997	10:10 PA
3	Examir		4a. Facility Neme (If not institution, give	e street and number)			4b. City, Town	, or Location of Death	4c. County	of Death	
1	- LAGITI		519 Park Ave.				Salis	bury	Wicon	nico	
	Funeral	Г	Social Security Number 6. S	ex 7. Age	(In yrs. last bir	thday) If Under 1	Year If Under 24	Hrs. 8 Date of Bird	h		place (State or Foreign
	Director		154-24-3903 Usual Residence of Decedent	∑ M 2□ F	78	Yrs. Months I	Deys Hours I	Min. (Month, Da April	30,1918	K J	
	2 should be filed within 72 hours after death with the Maryland end Mantel Hygiene. Is marked other than "natural", or Items 23a or 28a-f show sumatic event, the Medical Everrance must be notified as		10a. State 10b. County	1	IOc. City, Tow	n or Location				1	10d. Inside City Limits
	Many find	to	MD Wicon	nico		Calichu	~17				No Yes 2□No
	the 28a	Director	10e. Street and Number	IIICO		Salisbu 10f. Zip C			10g. Citizen of V	Whet Cour	ntrv?
	With Miles		519 Park Av								
	leath ms 2	era	11. Maritel Status	12. Was Decedent Ev	er in U.S.		21801 It of Hispanic Origin	? (Specify Yes or No	U.S.A.		can Indien,
	Her o	Funeral	1 Never Married 2 Married	Armed Forces?		If Yes, specify	Cuban, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	Biad	ck, White,	
21215-0020	II, or	by	3 ☐ Widowed 4 ☐ Divorcad	N Yes 2 ☐ No If Yes, Give Yeer or Detes: W	AI III y	1□ Yes 2√	No Specify:		Specify	. Wh	ite
ŏ	tura tura		15. Decedent's Ed			Decedent's Usual (Occupation		16b. Kind of Bu	usiness/in	dustry
5	in 72	Completed	(Specify only highest gra	de completed)			done during most of	working	100.14110	201110001111	adony
2	with iene. the	E	Elementary/Secondary (0-12)	College (1-4or 5+)		rector of	Ouality	Control	Glas	ss Co	
D	Hygie other	O	17. Father's Name (First, Middle, Last)			rector or		Name (First, Middle,			•
au	d be antel	o Be	Matthew		Cr	eamer, Sr	. Harr	iet		Da	ire
Maryland	Mark mark	10	19e. Informent's Name/Relationship (Tune Print)				or Rural Route Number	or City or Tourn		
S	s 1 and 2 should be filed within 72 hours after death with the Manylan I Health end Mantel Hygiene. I tam 27 Is marked other than "natural", or Items 23s or 23s-f show tiam 27 is marked other than "natural", or Items 23s or 23s-f show other traumatic event, Ite Medical Experience must be notified a							_		State, Zip	70000)
a)	permit. Pages 1 and 2 Department of Health e Important: If Itam 27 Is any Injury or other tra 900.0.		Ada Creamer - w:	TIE		19 Park A Disposition (Name		bury, MD	20c. Location -	City or To	own State
altimore,	Pages nent of h int: If its ury or of		1 ABurial 2 □ Cremation 3 □		cemete	ry, crematory or other	er placa)				
Ë	tant:		4 □ Donation 5 □ Other (Specif)		Frien			4-26-97	Bridge	eton,	N.J.
Bal	Depa Important Ir		21. Signature of Funeral Servica Licen	3 /	1	22. Name and	Address of Facility	705	E. Main	a St.	
	707 e 0		Quald (- / Four	nos	Bounds	Funeral H	0.1	isbury,		
			23 Part T. Enter the diseese, or comp shock, or heart feilure. List only	olications that caused the	e death. Do	nof enter the mode	of dying, such as car	rdiac or respiratory a	rrest,		Approximete Interval Between
9	Physician		/							1	Onset end Death
	/Medical		Immediete Cause (Final disease or condition	Malo	5+	Carr	innid	Funo.		4	years
	Examiner		resulting in death)	a. Ma/	ue to (or as a	consequence of):					
	n #	ner			,						
	ertificate be executed ling physician end e as the buriel-transit	Examiner	Sequentially list conditions,	b. Du	ue fo (or as a	consequenca of):					
o Ô	an er riel-t	EX	if any, leading to Immediate cause. Enter Underlying							1	
68760,	ysici ysici	edical	Cause (Disease or injury that initiated events	C. Du	e to (or as a o	consequence of):					
89	tifice g ph as th	Pe	resulting in deeth) Last							İ	
ŏ		M√III		d							
m	death c	Icla	Part II. Other significant conditions of	astribution to death but	not resulting in	the underlying ear	no sives in Bart I	23b Did	Inhana una ca	nádbada á	a the serves of death?
0	res that the designed by the a	Physician	Tarrii. Other arginicant conditions of	onthouting to death but t	not resulting in	Time underlying cau	se given in Fait i.				o the causs of death? bably 4 Unknown
J.	that bed	by P						_ 10	108 212740	3 F10	DEDIY 4 ONKHOWN
Records,	requires that the							24a. Wes	an eutopsy	24b. W	ere eutopsy findings
Ö	v require been si should	Completed							rmed?	co	vailable prior to empletion of cause
He He	has has	ш								of	death?
=	cate he							10	Yes 25 No	1[☐ Yes 2☐ No
Vital	ysician: The s certificate director, pag	Be	25. Was case referred to medical examiner?	Hamilal.				Death (Check only of	one)		
ō	Physiclan: this certific iral director,	2		Hospital: 1 ☐ Inpatient				ng Home 5 Resid			(y)
٦	ding P th. After t funera	i.i	27. Manner of Deeth 1. ■ Natural 5 □ Pending	28e. Date of Injury (Month, Day Y		Time of 28c njury	Injury at Work?	28d. Describe	how injury occur	red	
20	Attending ir death. sctor: Affer by the fune	cati	2 ☐ Accident investigation			М	1 ☐ Yes 2 ☐ No				
Division	or Attendated after deat Director:	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (- At home, fa	rm, street, factory, o	ffice	28f. Location (: City or To	Street end Numb	er or Rure	el Route Number,
2	rs af rs af al Di led ir	S									
	To the Hospital or Att within 24 hours aftar d To the Funeral Direct complately filled in by	edical	29a. Certifier CertifyIng Phy	ysicien: To the best of r	ny knowledge	, death occurred at	the time, dete end p	lace, and due to the	cause(s) and ma	enner as s	rated.
	in 24 he F he F	8	one)	end menner state	d.	a/or investigetion, in	my opinion, death c	occurred at the time,	dete end piece,	and due to	o (ne cause(s)
	To To To To To To To To To To To To To T	W	29b. Signature and title of certifier	1		29c. L	icense number		29d. Date signe	d (Month,	Day, Year)
		W	174	/act	M.D.	4	7 7069	6	Poril	23	1997
			30. Name and eddress of person who o	ompleted cause of dee	th (Item 23a)	Tuna Driet)					
			James P	Mar fin	MO.	195 1	E. Cora	1155.	5.1:0	600-	. MO
	Sta	ite	31. Date filed (MOAPR 24) 199	32 Registrar's	s Signature					7	,
	Registr		n 1 64 199	17 July da	valeon Re	dall					
				- U							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April **Physician** Vernon Henry 27, Cook 1997 1:15 am /Medical 4a. Facility Neme (If not institution, give streat and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Sociat Security Number If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth Jan 27, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Days Hours 907 Yrs. 213-09-9327 90 Director Maryland Usuat Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Explanation rules be notified at MD 1 ☐ Yes 2 ☐ No Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Holly Road 21146 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Maritel Stetus 13. Was Decedent of Hispento Ortgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Raca - American Indien, Biack, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Deputiment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or item. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Cabinetry 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Henry Lillie 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 15 Holly Road, Severna Park, MD 21146 Marlene Seiss/daughter 20b. Ptaca of Disposition (Name of cemetery, crematory or other placa) 20e. Method of Disposition 20c. Location - City or Town, State Date Apr 30 1 XBurial 2 ☐ Cremation 3 ☐ Removal from Stete Loudon Park Cemetery 1997 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Home Barranco & Sons, P.A. Severna Park Funeral 495 GovRitchie Hwy., Severna Park, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervat Between Onset and Death Physician /Medical Cardiopulmonary Examiner Acute and Chronic, Severe Rend failure Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting In deeth) Last physician a (ardiomyopothy Box 68760. Icchemic years Physician/Medical Due to (or es a consequenca of): Regurgitation Part ff. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Multi-infarct Dementia þ 24b. Were autopsy findings aveileble prior to completion of cause of death? Molnutrition 24a. Was an autopsy performed? Completed cartificata 1 Yes 2 No 1 Tyes 2 No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this cartificaletely filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier 1 Cartifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. completely (Check only one) To the Within 2

29c. License number

1037654

Ritchie Highway, Arnold, MD

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of our

31. Date fited (Month, Day, Year)

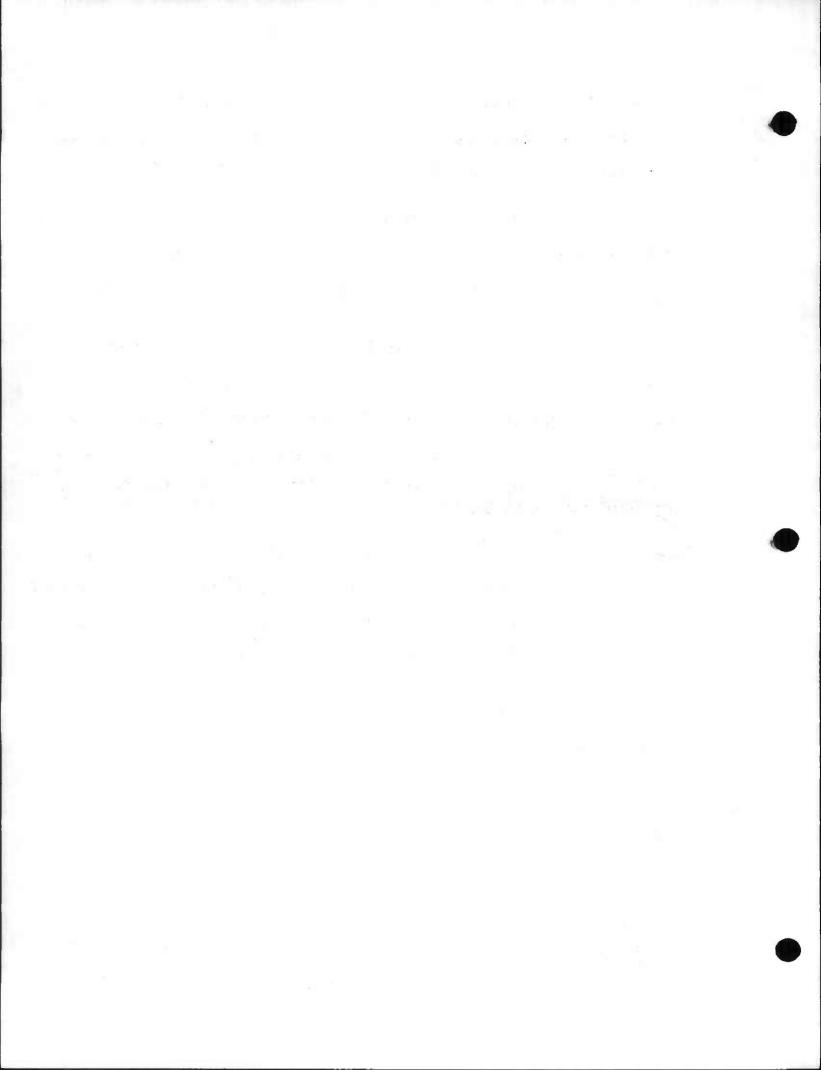
John C. Sellentrus

MAY 01 1997

ress of person who completed cause of deeth (ttem 23e) (Type, Print)

1509

32. Regispar's Signature
Suha Davidson-Randsee



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Vaar Month Grace Marion Clark 1997 29 April 6:20AM 4a. Facility Nema (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis If Undar 24 Hrs. 8. Anne Arundel 5. Social Sacurity Number If Undar 1 Year 6 Say 8. Data of Birth (Month, Dey, Year) 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) 1□ M 20 F Months Deys Hours Yrs. 217-34-8329 May 10 1912 Massachusetts Usual Rasidenca of Decedan 10a Stata 10b County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2000 Anne Arundel Severna Park 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 200 Lennox Avenue 21146 United States 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, spacify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indien, Black, Whita, atc. 1 Navar Married 2 Married 1 Yas 2 No Specify: Specify: White 3 ☐ Widowad 4 ☐ Divorced 15. Dacedant's Education 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) (Specify only highast grade complated) Elementery/Secondary (0-12) College (1-4or 5+) Teacher Ballet Industry 17. Fathar's Nama (First Middle Last) 18. Mothar's Name (First, Middle, Maidan Sumeme) Marion E. Provencher Ralph J. Gelinas 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) William Ellery Clark (Son) 200 Lennox Avenue Severna Park, Maryland 21146 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Burial 2 Cramation 3 Removal from State Forest Hills Cemetery May 2, 1997 Boston, Massachusetts 4 ☐ Donation 5 ☐ Other (Spacify) 22. Name and Addrass of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Virginia Sarvica Licensea 147 Duke of Gloucester St. Annapolis, MD21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Immediata Causa (Final disaesa or condition resulting in death) Due to (or es/a consequence of) Dua to (or es a consequance of) 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Was an autopsy performed? Wara autopsy findings available prior to Staphiaureus heel ulcer completion of cause of death? Hout

1 Yas

Physician /Medical **Examiner**

use as the buriel-transit

ettending physician

signed by the

certificate hes

After this

within 24 hours efter death. To the Funeral Director: Af

or Attending Physician:

Hospital

\$

requires that the deeth certificate be executed

Division of Vital Records. P.O. Box 68760.

Examiner

Physician/Medical

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Completed

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2

Medical Certification:

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Experies must be notified at

permit. Pages 1 end 2 should be filed within 72 hours effer i Department of Health and Mentel Hygiene. Important: if Itam 27 Is marked other than "natural", or ther any Injury or other traumatic event, the Medical Exerci

Baltimore, Maryland 21215-0020

the Maryland

death

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Ceusa (Disease or Injury that initieted avants resulting In death) Last

1 Yas 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Sulcide

29a. Certifian

4 Homicide

30. Nema and addrass of pers Janiel 31. Date filed (Month, Day, Year)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration

failur rena 25. Was case rafarrad to medical axaminar?

Hospital: 1 Impatiant 2 EF/Outpatient 3 DOA

28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)

28b. Tima of

26. Placa of Death (Check only one)

2 1 No

1 ☐ Yas 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work? 28d. Dascribe how Injury occurred

28f. Location (Straet and Number or Rural Routa Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and fitte of certif 29c. License number

Data of Injury (Month, Day Year)

29d. Data signad (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print) Konick, M.D. 180 Adm, Cochane Drive, Annapolis,

State Registrar

MAY 01 1997

5 Panding investigation

6 Could not be

32. Ragistrar's Signature

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

Director

Funeral

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Completed

Funeral Director

death with the Maryland 28a-f show ö Nerns 23a

traumatic event, the Medical Examiner naut be notified at permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health end Mantal Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Experimen-once.

Baltimore, Maryland 21215-0020

Physiclan /Medical Examiner

Examiner physician and the burial-transit The law requires that the death certificete be axecuted Physician/Medical for usa as signed by t þ Be Completed peeu pege 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director, t Certification: To edical

Records, P.O. Box 68760,

Division of Vital

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Campbell Irristine APRIL 30, 1997 15:10 PM 4e. Fecliity Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth THE JOHNS HOPKINS HOSPITAL BALTIMORE N/A 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) 05-26-1968 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2√□F Months Deys Hours 28 MARYLAND Yrs 220-58-1968 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No MARYLAND ANNE ARUNDEL FERNDALE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 411 ORCHARD ROAD 21061 II.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 11. Marital Status Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: WHITE 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede comp 16b. Kind of Business/Industry completed) Elamantary/Secondary (0-12) Coilege (1-4or 5+) FIRE PREVENTION ENGINEER N.I.H. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LLOYD ROBERT CAMPBELL JULIA BERNSCHEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) 411 ORCHARD ROAD, FERNDALE, MARYLAND JULIA CAMPBELL (MOTHER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY, INC. 5/3/97 BELTSVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 23a. Part1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each min. Onset and Death Immediate Cause (Final 5 days a. Cytomegalovirus pulumonitis
Due io (or as a consequence of): disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Due to (or as a consequence of) Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 25 No Disease 24b. Were autopsy findings evailable prior to completion of cause of daath? 24a. Was an autopsy performed? cardiomyopathy Yes 2 No 1 Yes 2 No

25. Was case referred to medical examiner?

23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No

28b. Tima of

27. Manner of Death 28a. Data of Injury (Month, Day Year) Natural 5 Pending Investigation 2 Accident

6 Could not be datermined

28c. injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To tha best of my knowladga, daath occurred at the time, date and piace, and dua to tha cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and piace, and due to the cause(s) and mannar stated.

29b. Signature and title of partifier eec.

3 Suicide

29a. Certifier

4 Homicide

29c. License number RES OOD 29d. Date signed (Month, Day, Year) 4/30/97

30. Nama and address of parson who completed causa of daath (Itam 23a) (Type, Print) Lili Barouch, Tower 110, Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, MD 21287 31. Date filed (Month, Day, Year) MAY 02 1997

State Registrar 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Rea No.

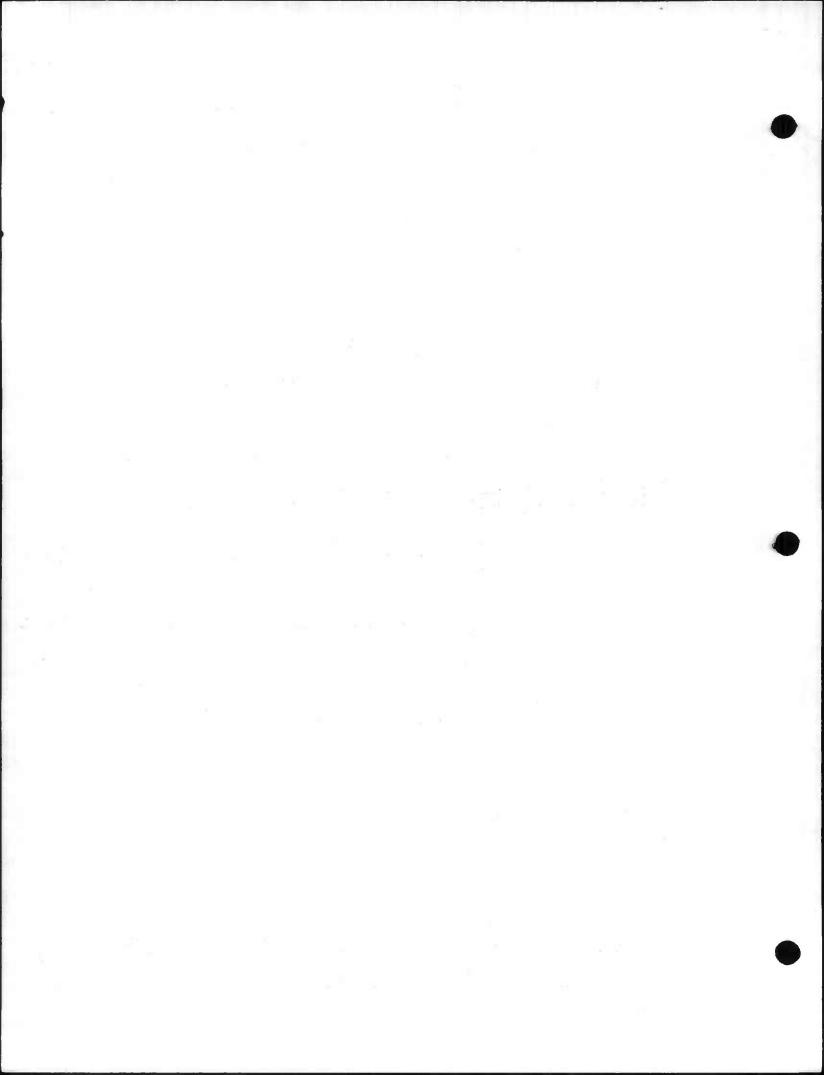
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	Physic /Medi		1. Decedent's Neme										A	2. Dete Monti	h	Day 28 1	Yeer 997		ma of Death 2:30 PK
	Exami		4a. Fecility Name (# Memorial F		ive street end no	umber)								ocation of	Deeth	4c. Count	y of Deet legar		
	Funeral Director		5. Social Security No. 215-20-6932	umber 6.	Sex 1□M 2X0F	7. Age (In 86	yrs. lest birt	hday) (rs.	If Undar Months	1 Yaa Deys	ır I	f Under Hours			of Birth h, Day, Ye			holeca (S	State or Foreign
	bue w		Usuei Rasidence of 10a. State	10b. County		10c	. City, Town	or Loc	ation			<u>_</u>						10d. fns	ide City Limits
	Many	tor	Maryland	Ailego	iny	F	rostburg	9											Yes 2□No
	of the	lrec	10a. Street end Num	bei35 Hill S	treet				10f. Zip	Code					10g.	Citizen of	What Co	untry?	
	23a c	la		1001111110						215	32-					U.S.A	١.		
020	be filed within 72 hours after death with the Maryland itel Hyglene. d other than "naturat", or items 23s or 28s-f ahow event, the Modical Examiner must be incrited at	by Funeral Director	11. Maritai Status 1 □ Never Merrie 3 □ Widowed		12. Was Dad Armed F 1 Yes If Yes, G Yeer or I	2 No	in U,S.		as Daced Yes, spec		of Hispenic Orlgin? (Specify Yes or No Cuban, Maxican, Puerto Ricen, etc.)					Ble	ce - Ame ack, White fy: White	e, etc.	en,
9	2 hours	bed		15. Decedent's I	Education		16e.	Decede	ent's Usue	I Occu	upetic	on			165	. Kind of E			
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Maryland	and Mentel Hygis s marked other surnatic event, I	To Be (17. Fether's Neme (I	opper							18			e (First, M et Har	iddle, Meli †le	den Sume	me)		
Mar	d 2 should th and Men 7 is marke traumatic		19e. Informant's Ne		(Type, Print) Son		19b.				et end		er or Rur heste		lumber, Ci	ty or Town		2161	_
d)	m 2		20e. Method of Disp		3011	20	b. Plece of	Dispos	ition (Ner	ne of			110310	Dete	_	. Location			
9	Peges ent of nt: If it		1 Buriai 2	Cremetion 3 5 Other (Spec		Stete			atory or o				01-1	lay-97		stburg			
Baltimore,	permit. Peges 1 Department of I Important: If ite any injury or ot once.		21. Signeture of Fur			/		22.	Nama an	d Addr	rass c	of Fecili						,	
m	Depariment Important Institution		100	ku K	Klury	1		Du	ırst Fu	nerc	H lc	lome	, 57 F	rost Av	ve., Fro	ostburg	, MD	2153	2
	Physician		23a. Park. Enter th	e diseese, or con t feliure. List ont	mplicetions thet y one ceuse on	caused the deech line.	deeth. Don	ot ente	r the mod	e of dy	/ing, s	such es	cardiec	or respiret	ory errest,			Interv	ximeta al Between and Deeth
П	/Medical Examiner		Immediete Cause (F diseesa or condition resulting in deeth)	inei	е. (CHF												3	day
		ē	rooming in doonly				to (or es e c	onsequ	ence of):	1							i		U
	outed ansit	Examiner	Sequentially list con-	ditions	b. Attal smallation Due to (6) es e consequence of):														
ó,	e exec ian ar urial-ti		Sequentially list con if eny, leading to im- causa. Enter Under Cause (Disease or in that initiated events	mediete lying			(0. 00 0		a. 100 01).								1		
68760,	certificate be executed ding physician and use es the burial-transit	n/Medical	thet initiated events resulting in deeth) L	ast	C	Dua t	o (or as a co	onsequ	ance of):										
ox 6	nding p	√/Me			l d												į		
œ		Iclar	Part II. Other signiffe	cant conditions	contribution to d	foath but not	regulting in	the un	torbine o		the contract	in Dort I		226	Didtoba		o a dulla colo	to the or	use of death?
P.0	that the death ned by the etter detached for	Physicia	Tarrii. Other signate	Danit Conditions	contributing to d	ieath but not	iesuiling in	ING UIN	Jerryang G	ause g	IVEI	III Pett I	•	230.	1 Yes				4 Unknown
	requires thet ween signed b hould be dete	by																	
oro	w requires to been signe should be	Completed												240.	Wes an e performed	utopsy 1?		eldeliava	opsy findings prior to n of cause
Rec	has has	idw														1		of deeth?	
Vital Records,			25. Wes case referre	ed to medical	1							0.5		101	1 Yes	2 0 No		1 □ Yes	2 No
>		o Be	examiner?		Hospitel:	Inpatient	2 🗆 ER/Out	nationt	3[] DO	Δ Ο	ther:			h (Check	Residence	6 F T Ot	her /Sne	0/6/1	
Jo L	afing Phys After this funeral d	T:U	27. Menper of Deeth			of Injury hth, Dey Yea				8c. inju	ury ef		Talling Tile		ribe how i			Jany)	
Siol	Attending or death.	atic	1 Neturel 2 Accident	5 Pending invastigetion	on	111, 20) · 02		jury	М			s 2 🗆	No						
Division	or Ath efter d Direct in by	Certification:	3 ☐ Sulcida 4 ☐ Homicide	6 Could not determine	4 288. PIBC	e of Injury - A ling, etc. (Sp	At home, fer ecify)	m, stre	et, fectory	, office	•				ion (Stree or Town, S		ber or Ru	ral Route	Number,
_	To the Hospital or Attend within 24 hours effer death To the Funeral Director: completely filled in by the	edical C	29e. Certifier (Check only one)	Certifying P	miner: On the b	e best of my pasis of exem	knowiedge, nination end	deeth	occurred o	et the t	time, opini	dete en ion, dee	d piace, th occurr	end dua to	the caus	a(s) end m end piace,	enner es	stated. to the ce	use(s)
	To the Within To the	Me	29b. Signeture end t	itie of certifier	1.							umber			29d.	Date sign	ed (Monti	h, Dey, Y	ear)
	4110			M CUU		MD se of death /	item 23a\ (Type P				112				4/3	0 9	7	
	jus		30. Name and address Nannette						l, Cun	nbei	rlar	nd, N	Marylo	and 2	1532				
	Sta Registr		31. Dete filed (Month	3 0 199	7 Julia	Registrer's S	igneture	Щ											

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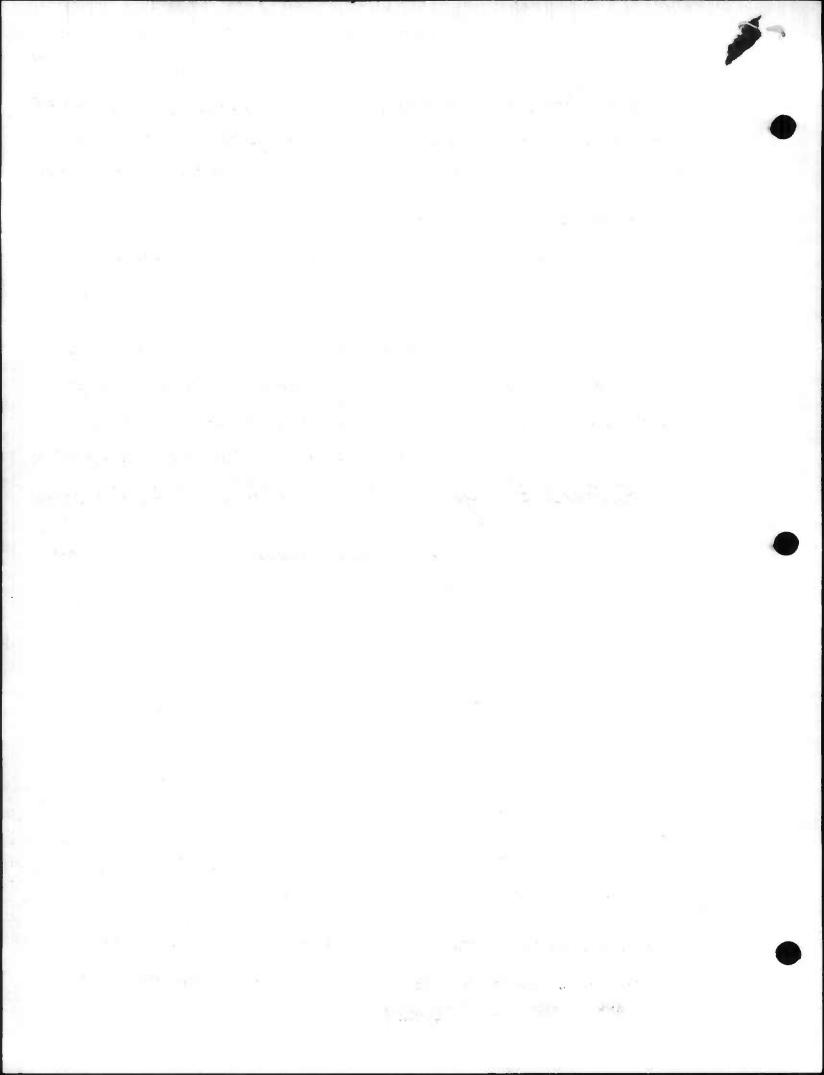
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							Cen	tificat	te of	Death			Reg. No.		
	Physic	ian	Decedent's Neme (First, Middle	e, Last)								2. Date of De Month	eath Dev	/ Year	3. Time of Death
U	/Medi		MARY FRANCES									MAY	4	1997	0320am
	Exami	ner	4a. Facility Name (If not institution	, give street and n	u <i>mber)</i>					4b. City, To	own, or L	ocation of Deat	h 4c.	County of Deeth	1
L			SACRED HEART H		_					CUMBI				ALLEGAN	ſΥ
	Funeral		5. Social Security Number 212–24–0272	6. Sex 1 ☐ M 2 □ r	7. Age	69 (In yrs. last bir	thday) Yrs.	If Unde Months			Min.	8. Date of Bir (Month, Da	th sy, Year)	9. Birth Con	nplace (State or Foreign untry)
	Director		Usuel Residence of Decedent	Λ	<u> </u>	09	113.					SEPT 7	1927	7 MAR	RYLAND
	and land		10e. State 10b. County			10c. City, Town	n or Loc	ation							10d. Inside City Limits
	Mary	to	MARYLAND ALL	EGANY		CRESA	РТО	WN							1 ☐ Yes 2√ No
	r 284	Director	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of What Cou	untry?
	death with the Maryland ms 23a or 28a-f show	0	14224 CUNNINGH	LAM DRIVE	S.V	7.			2150)5				J.S.A.	
	n 72 hours efter death with the Marylan "natural", or items 23a or 28a-1 show solical Examiner must be norified at	Funeral	11. Marital Status	12. Wes Dec	cedent 6	Ever in U,S.	13. W	/as Dece	dent of	Hispenic O	igin? (Sp	ecify Yes or No Ricen, etc.))-	14. Rece - Amer	
0	or its	3	1 Never Married 2 Marri	Armed F	E N	lo		Tes, spe ☐ Yes	-			Hicen, etc.)		Bleck, White Specify: WHI	
21215-0020	rai.	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Yeer or I	Detes:		1	105	S RT NO	Specify				Specify: ****	.16
5	filed within 72 hours efter Hygiene. ther than "natural", or fle ant, tre Medical Examine	Completed	15. Decedent (Specify only highes	's Educetion It grade completed,)	16a.	(Give k	ent's Usu	ork done	during mo	st of work	ina	16b. Ki	nd of Business/I	ndustry
72	within ene. than	I de	Elementery/Secondary (0-12)	College		+)	life. D	<i>O NOT</i> u	se retire	ed)			11/	NICE KEE	DED
	i Hygie other t	ပိ	1.0 17. Father's Name (First, Middle, I	(act)		нс	USE	KEE	PEK	40 Mark	ada Mass	- (Fi-1 1 8'-1 8'-		OUSE KEE	PER
Maryland	Mentel I Merked of arked of	Be	EDWARD CARROL	•								e (First, Middle, NOUCE	, Maiden	Sumeme)	
7	ges 1 and 2 should be filled within to Health end Mentel Hygiene. If item 27 is marked other than or other traumatic event, Ir a Me	2	19e. Informent's Name/Relationsh			106	Mailing	Addross	, (Stron				ar City a	r Town, State, Z	Va Cada)
Z	end 2 s ealth er n 27 is		FREDERICK N. C		D 1	IUSBAND							-	RESAPTOW	
e,	ges 1 end it of Health If item 27 or other tr		20e. Method of Disposition	OWGILL 3.	N I	20b. Place of	Dispos	ition (Na	me of		אַע דאַג	Dete Dete		cetion - City or 1	
timore,	Peges nent of I int: If ite		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc		State	REST L	-	etory or o			6 1	997		LE MARY	
a	구 등 후 후		21. Signature of Funeral Service L	- 0		1				ess of Facil	- 1				
ä	Depa Impo			P 11125	TH						-	AL HOME	Ξ		
			23a. Pert1. Enter the disease, or shock, or heart feilure. List of	complications that	caused	the deeth. Do n	40	4 DE	CATI	JR STF	EET	CUMBERI	LAND_	MARYLAN	Approximate
	Physician		shock, or heart feilure. List of	only one care e on	eech lin	θ.			,						Intervel Between Onset and Deeth
m'	/Medicai		immediate Cause (Final		(· · L	6	`^		V.	2	5			2 0-
	Examiner		disease or condition resulting in deeth)	a		Due to (or as e	> [(ance of):		wi	2	-			20075
	D #	ner		T	0	XC, C	(0	1	1.6	1			1	2 200,0
	certificate be executed iding physician and ise as the burial-transit	Examiner	Sequentially list conditions,	b. —		Due to (or es a c	onsequ	ence of:		1			- 0	()	Zeugs
Ö,	e exe		Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Diseese or injury		A	101	al	2/1		Car	18	~ 18	2 Ke	144	3 4x0 et
68760	ohysic the b	edical	thet initiated events resulting in deeth) Lest	C	۲۰۰۰	Oua o (or as a c	onseque	ence of):		^		7	1	9.	, , ,
9 XO	certifica nding pl use as t	υ/Me		a thi	17	ox y		OF 4	od	then	(a of	1	eus	3 1124
80	_ 63						7	V				0		0	101
o	law requires that the death es been signed by the atte s 2 should be detached for	Physicia	Part II. Other significant condition	ns contributing to d	deeth bu	t not resulting in	the unc	derlying o	euse gi	ven in Part	l.	23b. Did	tobacco	use contribute	to the cause of death?
م	that t ed by deta		140	ch	1	T WI	1	200	In	2		DE!	Yes 2	□ No 3 □ Pro	obably 4 Unknown
ds	sign ld be	d by		0	1	10				-		24a. Wes	on outon	24h V	Vere autopsy findings
Ö	been shou	ete											med?	a	valleble prior to completion of cause
Vital Records,	0 - 6	Completed											(E/ -r	44	f déeth?
ā	certificate	e Co	06 Mas associated to the first									10	Yes 2	No 1	☐ Yes 2☐ No
	ysician: s certific director,	00	25. Was cese referred to medicel exeminer? 1 \(\text{Yes} \) Yes	Hospital:		• • • • • • • • • • • • • • • • • • •			Oti	hor:		h (Check only o			
ō	rthis eral d	T: To	1 ☐ Yes 37 No 27. Menner of Death	28a. Date		28b. T		3□ DC	JA	4 L N		me 5 L Resident 28d. Describe I		Other (Spec	ify)
Division	iding Physic.: After this of funeral	to	1 Neturel 5 ☐ Pending 2 ☐ Accident Investig		nth, Dey		njury	М	28c. Inju Wo 1 ⊑	rk?]Yes 2□				,	
N S	Attender deeth ector:	Ifice	3 ☐ Sulcide 6 ☐ Could n	ot be 28e. Place		ry - At home, fer	m, stree	et, factory	y, office		-				rel Route Number,
ā	s afte	Certification:	4 Homicide	build	ling, etc.	(Specify)						City or Tov	wn, Stete))	
	To the Hospital or Attending Physician: within 24 hours after deeth. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier Certifying	Physician: To the	e best o	my knowledge,	death o	occurred	et the ti	me, date er	d plece,	end due to the	ceuse(s)	and manner as	stated.
	the Hin 24 the Fi	edical	one) 2 Medical E	xaminer: On the b	nor sia	ed amination and	Vor inve	stigation,	, in my o	opinion, dea	ith occurr	ed et the time,	dete and	plece, end due	to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature end title of certifier	11	()			290	c. Licens	se number		1	29d. Date	e signed (Month,	, Day, Year)
	4		P() 0 Kn	(700	110	auas	2	1	-	175	-2	6.	VAW	4th	11997
	DAL.		30. Name and eddress of person v	no completed caus	e of de	ath (from 238)	Type, P	int)	2			1 1	THE L	1112	
	10.00		Jehn Meha	nnaM	D.	4020	204	PN	Irl	ve (Un	nberla	nd	MP	11505
	Sta	-	31. Date filed (Month, Dey, Yeer)	7 Sala	Distra	is Signations	14								
	Registr	ar	MAYUS	0		YOU PARKE		75							



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						Cert	ificate of	Death		Reg. No.		
			1. Decedent's Neme (First, Middle, L	ast)					2. Dete of l			3. Time of Deeth
	Physic /Medi		LOUISE VIO	DLETTA	CAMPBE	LL			APRI	L 2 ~	1997	2145
	Exami		4e. Fecility Neme (If not institution, ga	ive street end nu	ım <i>ber</i>)			4b. City, Town, o	or Location of De	eth 4c. County	+-+-	
1			Washington Cou	unty Ho	ospital			Hagers	stown	Was	shing	gton
Н	Funeral		Sociel Security Number 6.	Sex	7. Age (in yrs. last bi		If Under 1 Year		rs. 8. Dete of E	Birth	9. Birthp	piece (Stete or Foreig
	Director		214-09-2533	1□M 2X)F	81	Yrs.	Months Deys	Hours M	JULY	31, 1915	Penn	Sylvania
	ש		Usuel Residenca of Decadent									
	h the Meryland r 28a-f show uncitined at		10a. State 10b. County		10c. City, Tov	vn or Loca	tion				1	Od. Inside City Limits
	Mer	to	Maryland Washir	gton	Hage	rsto	wn					1 XYes 2 No
	or 28	re	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Cour	ntry?
	72 hours effer death with the Meryland natural', or items 23e or 28e-1 show iteal Examiner must be notified at	Funeral Directo	1314 Potomac A	venue			217	42		U.S.	. A .	
	items 2	Jer	11. Maritel Stetus	12 Was Dac	edent Ever in U,S.	13. Wa	s Decedent of I	Hispenic Origin? en, Mexican, Pu	(Specify Yes or I	No- 14. Rec	ca - Americ	
0	ours efter d al', or iten	E	1 ☐ Never Married 2 ☐ Merried	Armed F	2 🔼 No				erto Rican, etc.)		ck, White,	
21215-0020	al', c	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Yeer or I	ive Detes:	1L]Yes 2∭ No	Specity:		Specif	y: WIT	ite
9-0	"natural",	Be Completed	15. Decedent's E	ducation	16e	Deceder	nt's Usuel Occu	petion		16b. Kind of B	usiness/inc	dustry
21	c	Pe	(Specify only highest gi Elementary/Secondery (0-12)		1-4or 5+)	life. DC	na or work done NOT use retire	during most of w	vorking			
21	d wit	PO	11	comogo (5	Secr	etary			Aircra	aft N	٩fg.
	Hygin Hygin other	e	17. Fether's Neme (First, Middle, Las	t)				18. Mother's N	leme (First, Midd	lle, Maiden Sumer	пө)	
19	should be filed within and Mentel Hygiene. marked other than ametic event, the Mentel Head	ToE	Carl Philip	o Bo	ger			Mabe:	l Eli	zabeth	Н	oover
Maryland	2 should end Men is marks	-	19e. Informent's Neme/Reletionship	(Type, Print)	191	b. Mailing	Address (Street	t end Number or	Rural Route Nun	ber, City or Town	, State, Zip	Code)
	od 2 lith e		Carl C. Kidw:	iler						own, Md.		
9	ges 1 and 2 should be filed with it of Health end Mentel Hygjene. If Item 27 is marked other than or other traumatic event, the Mentel Health ender the mentel of the Mentel Health ender the Mentel H		20a. Method of Disposition		20b. Plece o	of Disposit	ion (Neme of		Dete	20c. Location		
Baltimore,	permit. Pages 1 and 2 s Depertment of Health er Important: If Item 27 is any Injury or other trau		1 Departies 5 Commetter 3		State Rest.	Hav	tory or other ple	neterv	h4-28-9	7 Hagers	town	Maryland
	it. Portme		4 ☐ Donetion 5 ☐ Other (Special Signature of Funeral Servica Lica	**	11000				1			ridi y idirid
Ba	Depening Depening Important Information In		21. Signeture of Purieral Servica Lice	1 2	- 1	An	drew K.	Coffmar	Funera	l Home,	Inc.	
			To. Mall	120	ray	40	East A	ntietam	Street,	Hagerst	own,	Md. 21740
			23a. Pert1. Enter the diseese, or cor shock, or heert feilure. List only	nplications that one cause on	caused the deeth. Do	not enter	the mode of dyi	ng, such es card	iac or respiretory	arrest,	1	Approximate Intervel Between
	Physician							4				Onset end Deeth
10	/Medical		fmmediete Ceuse (Finel diseese or condition		Henry	ito-	henal	Failur	4			1 mo
	Examiner	١.	resulting in deeth)	θ	Due to (or es e	conseque	ence of):	Jacker				
_	p .=	nei			6 cm le	un	mass					142.
	sertificate be executed ding physician end se es the bunel-transit	/Medical Examiner	Sequentially list conditions,	D. —	Due to (or es e	conseque	nca of):					
ó	an e	Ä	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury								i	
68760,	ysic he bi	ca	thet initiated events resulting in deeth) Last	C	Due to (or es e	conseque	nca of):					
	tiffica ng ph es ti	Ped	resulting in deetil) Last								į	
Box				d							<u>_</u>	
	law requires thet the death cert es been signed by the attendin 2 should be deteched for use	Physician	Pert II. Other significent conditions	contributing to d	eeth but not resulting i	in the unde	erlying cause di	ven in Pert f	23h. Di	d tobacco use co	ntribute to	o the cause of death
0	t the by th	hys				uno arra	onymig oddoo gi	voir mir one i.		Yes 28(No		bably 4 Unknow
	the dele	by P							_ ''	_ 100 _ 12410	0	outly 45 official
ď	uld bu	D D								es en eutopsy		ere eutopsy findings
00	w require been si should	ete							ре	rformed?	CO	eileble prior to empletion of cause
Re	hes ge 2	Completed										death?
a	icate h								1[Yes 2 No	1 [☐ Yes 2☐ No
of Vital Records,	Physiclan: The is this certificate he ral director, page	Be	25. Wes case referred to medical examiner?	Hospital:			04		eath (Check onl	y one)		
ō	Phys this ral dii	10	1 ☐ Yes 2 ☑ No	128	Inpatient 2 ER/O	-	3LI DON		1	sidenca 8 □Oth		y)
Ē	After funer	Certification:	27. Menner of Deeth 1 ☑ Neturel 5 ☐ Pending	28a. Date (Mor		Time of Injury	28c. Inju Wo		28d. Describ	e how injury occur	rred	
Sic	Attending or death. ector: After by the fune	catl	2 Accident investigetion				M 1	Yes 2□No				
Division	or Attended of the destination o	ţĮ.	3 ☐ Suicide 6 ☐ Couid not le determined	28e. Piece build	a of Injury - At home, fa ing, etc. (Specify)	arm, stree	t, fectory, offica			(Street end Numi	ber or Rure	I Route Number,
	tal or rs efter al Dir	Cel										
	hour uner ly fit	cal	29a, Certifier Certifying Pl	hyelcfan: To the	best of my knowledge	e, death o	ccurred et the ti	me, dete end ple	ce, end due to th	e ceuse(s) end m	anner as s	teted.
	To the Hospital or within 24 hours effet To the Funeral Dir completely filled in	edical	one) 2 Medical Exa	end men	esis of exemination er ner stated.	WUT INVES	augenon, in my (opinion, geeth oc	curred et the tim	e, aete ena piece,	and due to	ule cedse(s)
	Tot Tot Com	Σ	29b. Signeture end title of certifier				29c. Licens			29d. Dete signe		
			Hurvean Tr	iles 9	~ mg		00	,		4-26	97	
			30. Name end eddress of person who	-		(Type, Pri	int)			rux ma	,	
			HAROLD R		1	1	348 hu	119f H	ACERSIZ	ww md	20	rho
	Sta	ite										
	Regist		31. Date filed (Month, Day, Year)	151 /4	egistrar's Signeture	بالعامق						



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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-1	100	1.1	-	4	- 81
1		2-60	U	-	-

1	Physic	ian	Decedent's Neme (First, Middle,	Last)						2. Dete of D Month	eeth Day	Year	3. Time of Death	
/Medical			DAVID MESSICK DAYTON								L 221		2010	
3	Exami	ner	4e. Fecility Neme (If not institution, give street and number)											
1			PENINSULA REGI	ONAL MEDIC	AL CEN	TER			SALIS		W	COMIC	30	
	Funeral Director		220-26-3532	. Sex 7. A	ge (In yrs. les. 74	t birthdey)_ Yrs.	If Under 1 \ Months D	rear Deys	If Under 24 Hrs Hours Min.	(Month, L	irth Dey, Year) 9/1922	(ear) 9. Birthplece (State or Foreign Country) Maryland		
	pu a		Usuel Residence of Decedent 10a. Stete 10b. County		100 City 7	own or Loca	tion						104 1 14 00 11 0	
	e Maryle	Director	Md. Wico	mico	Toc. Oity, I	Biva							10d. Ineide City Limit	
	1 th	Ore	10e. Street end Number				10f. Zip Co	ode			10g. Citizen ot	What Cou	ntry?	
	th w													
21215-0020	72 hours after deeth with the Maryland Instural; or Rems 23s or 28s-f show Unal Examiner must be notified at	by Funeral	11. Meritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces 1 Types 2 If Yes, Give Year or Detes	[?] _{No} W ₂ W.	13. W	as Decedent res, specify	Cubar	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yea or N to Rican, etc.)	v Yea or No- 14. Rece - American Indie			
15-0	30	Completed	15. Decedent's (Specify only highest)	Education grade completed)	le completed) (Give kind			done di	unna most of wo	rking	ina 16b. Kind of Busin		inass/Industry	
121		d L	Elementary/Secondery (0-12)		Coilege (1-4or 5+)					7/2	2			
		ပိ	11 17. Fether's Neme (First, Middle, La	4		Heal	th Ir		rance	mo /First Middle	Distr e, Meiden Sume	istrict Manager		
ano	od of o	Be										me)		
2	should be ind Mentel marked or umetic eve	2	Brady Jame							Messic				
e, Maryland	U 00 m m		19e. Informent's Neme/Reletionship								ber, City or Town			
	1 end 3 Heelth em 27		Jane W. Dayte 20e. Method of Disposition	on	20h Plac	P.O. e of Disposi	BOX	42	, Biva	lve, M	arylan 20c. Location			
٥	@ D		1 Buriai 2 ☐ Cremetion 3		cem	etery, creme	tory or othe	r plece						
tim	ther tent:		4 ☐ Donetion 5 ☐ Other (Spe	**		alve					Bival			
Baltimore,	permit. Pege Department of Important: if eny injury or once.		21. Signeture of Funeral Service Licansee MOO-417 22. Name end Address of Fecility Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814											
	Physician /Medical Examiner		23e. Part 1. Enter the disease, or or shock, or heert feliura. List on tmmedieta Ceusa (Finat disease or condition rasulting In deeth)			(14	1~5		, such es cardie		errest,		Approximete Interval Between Onset end Deeth	
ox 68760,	eth certificate be executed effending physician and for use as the bunel-transit	clan/Medical Examiner	Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Last	b	Due to (or es	e conseque		3 6	5					
B	etter for u	clar												
, P.O.	es that the de igned by the be detached	/ Physi	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to 1 Yes 2 No 3 Pro										o the cause of death bably 4 Unknown	
of Vital Records,	requir been s should	Completed by								24e. We per	s an autopsy iomed?	av	are eutopsy findings valleble prior to completion of cause death?	
æ	The law ata hes page 2	E								1	Yes 2 2*No		□Yes 2□No	
a		Bec	25. Wes case reterred to medical				26. Placa of Daath (Check only ona)							
>	Physician: this certific	To B	axaminer? 1 ☐ Yas 2 ☐ No	Hospital:	osnital: Other:							her (Snecil	6/1	
	문 문 교		27. Menner of Deeth	28e. Dete of Inj (Month, D		b. Time of	te of 28c. Injury et 28d. Describe how injury occur						77	
<u>o</u>	tending Ph leath. lor: After thi the funeral	atio	1.ÆNaturel 5 ☐ Pending 2 ☐ Accident Investigat		(Month, Dey Year) Injury M									
Division	al or Attending s after death. I Director: Afte id in by the fune	Certification:	3 Suicide 6 Could not determine	A 286. Piece of in	jury - At home ic. (Specify)	, ferm, stree	t, fectory, office 28f. Location (Street and Number City or Town, State)				ber or Ruri	al Route Number,		
	To the Hospital or Atte within 24 hours after de To the Fureral Directo completely filled in by th	edical C	29e. Certifier (Check only one) 1 Certifying I	Physician: To the best aminer: On the basis of end menners	ot examinetion	dge, deeth o end/or Inve	ccurred et ti stigation, in	he time my opi	e, data and plece inion, deeth occu	a, and due to the urred et the time	e ceusa(s) and m	anner as s , and due to	iteled. o the cause(s)	
	Withir To th	Me	29b. Signature end title of certifier				29c. Li	icense	number		29d. Dete sign	ed (Month,	Dey, Year)	

D29168

30. Neme end eddress of person who completed cause ot deeth (Item 23e) (Type, Print)

Dv Robert Allen,
31. Date tiled (Month, Day, Year)
APR 281997 614 C Exptern Shore Drive - Salisbury Md. 21801

State Registrar 32. Registrar's Signetura

State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate	e of	Death	•		Reg. No.	2.1	14011
			1. Decedant's Nama (First, Middla, Las	st)							2. Data of Dea	ath	Vere	3. Tima of Death
П	Physici /Medi		Harrison Nathani						April	7,	1997	10:00 AM		
		Examiner 4a. Facility Nama (If not institution, giva street and number)							4b. City, To	wn, or Lo	ocation of Daath	4c. County	y of Death	
			5666 Castle Hill Road Snow Hill						Hill		ter			
	Funeral Director		201-10-8249	ax 7. Age	7. Aga (In yrs. last birthday) 1. Aga (In yrs. last birthday) 1. Months Days Ho						8. Data of Birth (Month, Day, Year) 9. B (Oct. 25, 1918 Nor			placa (Stata or Foreign ntry) h Carolina
	and **		Usual Rasidance of Decedant 10a. Stata 10b. County		10c. City, To	own or Lo	cation				_			10d. Insida City Limits
ary (and 21215-9020 should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23e or 28e-f show urnetic event, the Medical Examinat must be portified at	Annylu P sho	ō		-010		ow Hi								1 ☐ Yas 2X No
	the h	ect	Maryland Worcest 10a. Street and Number	.er	3110	OW III	10f. Zip	Code			· ·	10g. Citizan of	What Cou	ntn/2
	With No.	Funeral Director	5666 Castle Hill	Poad			TOI. Zip	218	363				JSA	nuy r
	death me 2	hera	11. Maritai Status	12. Was Decedant E	var in U,S.	13. V	Vas Deced			igin? (Sp	ecify Yas or No- Rican, atc.)			cen Indian,
	urs after al', or ite	þ	1 ☐ Never Marriad 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forcas? 1 🛛 Yas 2 🗍 N If Yas, Giva Year or Datas:			fYas, spec I□Yas 2				Rican, atc.)		ick, Whita, Äfric	an America
21215-0020	72 ho	Completed	15. Decedant's Ed (Specify only highest gra	lucation		Ba. Deced	lent's Usua	i Occu	pation	t of work	ina	16b. Kind of B		
7	ithin in	nple	Elemantary/Secondary (0-12)	Elemantary/Secondary (0-12) College (1-4or 5+) lifa. DO NOT usa retired)					R OF WORK					
	ygien A th	Con	10th grade								Board of Education			
yland	be filed tal Hyg d other event,	Be	17. Fathar's Name (First, Middle, Last)		C						a (First, Middla,	Maldan Sumai	na)	
	Merke Merke Merke	2	Harrison Nathani			_					Tate			
Mar	d P a a b a b a b a b a b a b a b a b a b		19a. Informant's Name/Raiationship (7	Type, Print)			_	,			al Routa Numbe			o Code)
Heal Heal	leaf leaf		Elbert Davis/son 20a. Mathod of Disposition		-		1 OWE1		rive -	· 2110	W Hill,	20c. Location	1863	own State
	not of not of t: If h		1 ☑ Burial 2 ☐ Cramation 3 ☐		cems	tary, cran	natory or of	thar pla		1.				
	permit. Pages Department of Important: If It any Injury or once.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licery	·	Mt.	Wesle	y Chu	Jrch	n Cem.	04	/12/97	Snow Hi	11,	Maryland
ď	Dep		1213 Jersey Road - Sarisbury, P											
	_		23a. Part I. Enter the disaase, or comp	f Alle	Ma dooth D				moria					21801
	Dhamistan		shock, or haart failura. List only	ona cau ia on aach i	yia daa(ii. D	o not and	ar tria irrodi	a or dy	ing, soci as	Cerdiac	or raspiratory at	1951,	1	Approximata Intarval Batween Onset and Death
	Physician / /Medical		Immediate Causa (Final	1,		1	,			5	m = 11 0	1011	1	
	Examiner		Immediate Causa (Final diseasa or condition rasulting in death) a. Lung Carcinoma – Small Cell 4week									4 week		
		Jer		,	Jue to (or as	a conseq	uance of):							
	outed nament	Examiner	Sequentially list conditions	b	Due to (or as	a conseq	uance of):					_	- !	
Ď	an ar	Ex	Sequentially list conditions, if any, laading to Immediate causa. Enter Underlying Cause (Disease or Injury that initiated avants Due to (or as a consequence of):							1				
09/99	icate be axecuted physician and s the bunal-transit	edical	Cause (Diseasa or Injury that initiated avants that initiated avants around the consequence of):											
õ ×	certificate be axecuted nding physician and use as the burial-transit	Mec												
o n	death ce a attend ad for us			d				-						
	v requires that the death certific been signed by the attending p should be detached for use as	Physician	Part II. Other significant conditions co	ontributing to death bu	t not rasuiting	g in tha ur	ndarfying ca	ausa gi	van In Part	l.	23b. Did t	obacco use co	entribute t	to the cause of death?
7.	hat the od by detac		Cerebrolas-ular Acoldent 1040						Yes 2□ No 3□ Probably Unknown					
g,	requires that seen signed b hould be deta	d by			, - 0, 0						041111111111111111111111111111111111111		0.4h 14	fore autorou fin days
cords	requ	etec	Hypertensio	3 ~							perfo	an autopsy med?	av	/are autopsy findings vallable prior to ompletion of cause
ě		Completed	0-11	Sil									of	daath?
\ Ital	iclan: The lav certificata has rector, page 2		Parlansons	Disease	?						101	as 2 No	1	Yas No
<u> </u>	Physician: r this certific rrai director,	o Be	25. Was casa referred to medical examinar?	Hospital:				Ot	hor		h (Check only o			
5	Phys r this and di	\vdash	1 ☐ Yas 2 ☐ No 27. Manner of Death	1 Inpatiar 28a. Data of Injury		Outpatien Tima of		A	4 🗆 140	ursing Ho	ma 5 Rasid 28d. Dascribe I	lence 6 Otl		<i>fy</i>)
JIVISION	Attending or death. ector: After by the fune	tion	Naturai 5 Panding 2 Accident Invastigation	(Month, Day	Year)	Injury	М	Bc. Inju Wo 1 □	nk?]Yas 2∐			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Atter or dea octor by the	Hica	3 Suicida 6 Could not be detarmined	28a. Place of Inju	ry - At home,	farm, stre	eet, factory	, office			28f. Location (S	Street and Num	ber or Rur	ral Routa Number,
5	s after in Direction	Certification:	4 Homicida	building, afc.	(Specify)						City or Tox	m, Stata)		
	To the Hospital or Attending Physician: To the Funeral Director After this certific Completely filled in by the funeral director.	edical (29a. Cartifiar (Check only one) 2 Medical Exam	yaician: To the best of iner: On the basis of and manner state	axamination:	lga, daath and/or Inv	occurred a astigation,	at tha ti in my	ima, data ar opinion, dea	nd place, ith occurr	and dua to tha e	causa(s) and m data and place,	annar as s and due t	stated. to the cause(s)
	To the To the comp	ž	29c. Licansa number 29d. Data signed (Mon								d (Month,	Day, Year)		
		de	Straion 1	1 Wes	200	MAY	1	14/	586	- M	10	4/15	197	7
		14	30. Name and address of person who,o	completed causa of da	ath (Itam 23	a) (Type, I	Print)	, ,	/		_			
		10	106 Mily	Bard 3	54.	5	all	360	m,	M	0 2	1804	/	
	Sta	_	31. Data filed (Monti APRY Par 6 10	97 32. Registra	Signatura	P.			//					
	Registr	ar	2015	J. J.	- market	- Martia	Ц							

State of Maryland / Department of Health and Mental Hygiene 9 7 14518 Certificate of Death

			1. Decedent's Neme (First, Middle, L.	ast)						2. Dete of De	eth		3. Time of Deeth	
	Physic		Mary Knight Duckett							Month April	30 1	997	4:45AM	
	/Medi Exami		4a. Facility Neme (If not institution, give street end number) 4b. City						b. City, Town, or Lo					
	LAGIIII	ici		inger Cove Health Care Facility							Anne Arundel			
	Funeral					lest birthday)	If Under 1 Y		Annapol:	8. Dete of Bird (Month, De			ca (State or Foreign	
١	Director		214-14-2257 Usuei Residence of Decedent	1□M 2X0F	92	Yrs.	Months De	eys	Hours Min.	Oct 18	1904	Mary	land	
	and w		10a. Stete 10b. County		10c. City	, Town or Loca	ation					100	d. Inside City Limits	
	e Maryl	ctor	MD Anne A	rundel		Annap	olis						1 ☐ Yes XXNo	
020	ath with th	Funeral Director	10e. Street and Number 4000 River Cre	scent Driv	re		10f. Zip Co		21401			What Countr ted St		
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medicel Examiner must be notified at	by	11. Meritel Stetus 1 Never Merried 2 Merried 3\times Microwed 4 Divorced	12. Wes Decedent Armed Forces 1 Yes 27 If Yes, Give X Yeer or Detes:	No		es Decedent Yes, specify (Ilspenic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	y Yes or No- an, etc.) 14. Reca - American Indian, Bleck, White, etc. Specify: White			
21215-0020	n 72 hours "natural", edical Exa	Be Completed	15. Decedent's E (Specify only highest gr		18e. Decedent's Usuel Occupetion (Give kind of work done during most of worki life. DO NOT use retired)				ing	16b. Kind of B	Business/Industry			
5	with! ene. then	E C	Elementery/Secondery (0-12)	College (1-4or	5+)		Homemaker				Hos	Home		
	Hygi ther mt, t	Ö	17. Fether's Neme (First, Middle, Las	()				CEL	18. Mother's Nem	e (First, Middle,				
an	d be	B	Thomas Jefferso	•	ım					erine P				
imore,	12 should be filed within hand Mental Hygiene. The marked other than "reumatic event, the Mes	2	19e. Informent's Neme/Reletionship			19b Meiling	Address (St	reet				ity or Town, Stete, Zip Code)		
	and 2 :		Warren B. Ducket		n)						, Maryland 21401			
	ges 1 and 2 should be filed within to f Heelth and Mental Hygiene. If frem 27 is marked other than or other treumstic event, the Me		20e. Method of Disposition	, 51. (50	20b. Pl	lece of Disposi	tion (Neme o	of		Dete Dete	n, Stete			
	Peges nent of I ant: If its ury or o		turBuriel 2 ☐ Cremetion 3 [4 ☐ Donetion 5 ☐ Other (Speci	Removel from State		Anno I	-			1997	Annano	lie N	(anyland	
	しかやう		St. Anne's Cemetery May 5, 1997 Annapolis, Mar 21 Sanature of Fermina Service Licensee 22 Name and Address of Facility John M. Taylor Funeral Ho											
ä	Depariment Important		147 Duke of Gloucester St. Annapolis, MD 2											
			23a. Pert1. Enter the disease, or conshock, or heert feliure. List only	nplications thet cause one ceuse on each il	d the deeth						-		Approximate ntervel Between Onset and Deeth	
	Physician /Medical		Immediate Cause (Final		3									
	Examiner		disease or condition resulting in death) e. UZ ILV2 N T A									418		
		Je.			Due to (or	r es a consequ	enca of):					1		
	eth certificete be executed ittending physician and for use as the burial-transit	an/Medical Examiner	Sequentially list conditions	b. ————	b. — Due to (or as e consequence of):									
ó	an an rial-tr	E S	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events											
928	ite be nysich	cal	that initieted events The subject of the consequence of the consequen											
Box 68760,	eth certificete be executed ttending physician and for use as the burial-transit	Med	resulting In deeth) Last									i		
30	th ce tendii	an		d								1		
	8 8 8	sic	Pert II. Other eignificant conditions	contributing to death b	ut not resu	itting in the und	lerlying cause	e giv	en In Pert I.	23b. Dld 1	obacco use co	ntribute to t	he cause of death?	
. P.O.	that the ed by detac	by Physic								10	Yee 2□ No	3 Probe	bly 4 Unknow	
	a law requires t has been signe je 2 should be	Completed by								24a. Wes perfo	an autopsy rmed?	com	e eutopsy findings able prior to pletion of cause eath?	
R	0 - 6	NO.				101	res 2 XNo	OXNo 1 □ Yes 2 □ No						
Vital		Be (25. Wes case referred to medical examiner?	26. Pleca of Deeth (Check only one)										
of V	5 0 0	ပို	1 ☐ Yes 2 XVo	Hospitel: 1 Inpatio	ent 2 🗆 E	ER/Outpetient	3□ DOA	Oth	er: 4 Nursing Ho	me 5 Resid	dence 8 🗆 Ott	er (Specify)		
			27. Mennar of Death 1 Proture 5 Pending	28a. Dete of Inju (Month, De	28b. Time of Injury	Injury W		y at k?		d. Describe how Injury occurred				
Division	Attender deatlector:	Certification:	2 Accident Investigetic 3 Sulcide 8 Could not t 4 Homicide determined	00 - 01(1-)	ury - At ho c. (Specify	me, ferm, stree		1 ☐ Yes 2 ☐ No ffice 28f. Location (Street end Number or Rural Route City or Town, Stete)			Route Number,			
	the Hospital or hin 24 hours afte the Funeral Dir npletaly filled in	edical C	29e. Certifier (Check only one) 1 Certifying Pl	nyelclan: To the best miner: On the besis o end menner st	examineti	viedge, deeth o	occurred et th stigation, in r	ne tim	ne, dete end piece, pinion, deeth occur	and due to the red et the time,	cause(s) end modete end plece,	enner as ste end due to t	ted. ha cause(s)	
	the the	Me	29h Simelure and title of certifier-	and manner st			290 110	2000	e number		29d Date slone	d /Month D	av Vasrl	

1)30708

May 1, 1997

State Registrar

D. Toeckson Ald; 2003 Mad. Alkony 400, America, Led 28461 n. Dey, Yeer) 32 Registrer's Signeture 31. Dete filed (Month, Dey, Yeer)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene

14519

						Cer	uncau	e or	Death		F	Reg. No.			
ı	Physic		1. Decedent's Name (First, Middla, I	DUNCO	in						2. Dete of Dea Month	th Day	ď7	3. Time of Death	
8	/Medi		4a. Facility Nama (If not institution, g						4b. City. To	wn. or L	ocation of Death	th 4c. County of Death		3	
A	Exami	ner	2120 TIMELESS DR		,								ALVER	T	
-					na (In vrs. las	ne bireb da u	If Under	1 Vaar	ST. L						
	Funeral Director		214 34 2116 Usual Residence of Decedent	1⊠M 2□F 6		Yrs.	Months	Days	Hours	Min.	8. Dete of Birth (Month, Day NOV 15,	1935	9. Birth Cou MARY	plece (Stete or Foreign ntry) LAND	
	show thow	_	10e. Steta 10b. County		10c. City,	Town or Loc	cation			:			10d. Inside City Limits		
	Berring Market	Director	MD ALLEGA	NY	FROS	STBURG	1							XIX Yas 2 □ No	
	# 50 E	Oire	10e. Street and Number				10f. Zip	Coda				10g. Citizen o	of What Cou	ntry?	
	êh w 23€		230 WELSH HILL				2	2153	32			U.S			
120	be filed within 72 hours after deeth with the Meryland hal Hyglene. I other than "natural", or thems 23s or 28s-f show event, its Medical Examiner must be notified at	by Funeral	11. Marital Stetus 1 □ Never Merried 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Wes Decedant Armed Forces 1 🗓 Yes 2 🗍 If Yes, Giva Yaar or Detes:)	- I	Vas Deced Yas, spec			gin? (S) i, Puarto	pecify Yes or No- Rican, atc.)	14. R B	ace - Amari leck, White, city: WH		
5-00	72 hou natural	eted	15. Decedent's (Specify only highast g	Education		16a. Deced	kind of wor	k done	during most	t of wor	kina	16b. Kind of	o. Kind of Business/Industry		
Baltimore, Maryland 21215-0020	filed within Hyglene. ther than •	Completed	Elemantery/Secondery (0-12)	College (1-4or	5+)	life. D	O NOT us TEMS	a retire	d)			TIR	E		
	illed I Hygl other	Bec	17. Fether's Nema (First, Middle, Las	st)						r's Nem	ne (First, Middle,				
lar	should be of Mental marked o	To B	FRANK DUNCAN						NO	VEL	LA STEVE	NSON			
ary	S D E E		19e. Intorment's Neme/Reletionship	(Type, Print)		19b. Mellin	g Address	(Street	end Numbe	or Ru	ral Route Numbe	r, City or Tow	m, State, Zij	p Code) 21532	
Ξ	nd 2		DONNA NOLAN/DAUG	HTER										BURG, MD	
more	8055		20a. Method of Disposition 1												
Balt	permit. Peg Department Important: if eny injury o		Signature of Feneral Service Lie Service Lie Service Lie Service Lies on coshock, or heert feilure. List online	(M) 16.	d the death.	/ SO	WERS	FIIN	ess of Fecility NERAL NERAL ng, such as	HOM	E, P.A. OSTBURG, or respiretory er	MD 21	532	Approximate Interval Between	
	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition rasulting in death)	. Non-su	Due to (or e	ell 1	uun							Onset and Death Zwarths	
-	D #	ine	_	. b									i		
oʻ	certificate be executed nding physician and use as the buriel-transit	Examiner	Sequentielly list conditions, if any, leeding to immadiete cause. Enter Underlying Ceuse (Diseess or Injury that initieted events	V	Due to (or a	is a consequ	uence of):								
68760,	ficete by physic as the b	n/Medical	thet initiated events resulting in death) Last	C. ————	Due to (or e	s e consequ	ence of):								
Box	att att	slan/N		d											
, P.O.	that the d led by the detached	by Physicia	Part II. Other significant conditions	contributing to death b	ut not rasulti	ing in the un	derlying ca	ause gi	van in Pert I.			obacco use d /es 2□No		o the cause of death	
Records,	law requires as been sign 2 should be	Completed b									24a. Wes perfor	an autopsy med?	av	Vere sutopsy tindings velleble prior to completion of cause i death?	
	0 - 6	mo									1 D Y	es 23 No	11	□Yes 2□No	
Vital		0	25. Wes case referred to medical				26. Plece of Deeth (Check only one)								
		O B	exeminer? 1 ☐ Yes 2 > No	Hospitel:	ent 2 EF	3/Outpatient	3□ DO	A Ott	oer:		ome 5 Resid		Other (Specia	(v)	
n of	ng Phys ftar this ineral d	on: T	27. Menner of Death	26a. Dete of Inju (Month, Da	iry 2	8b. Time of Injury		Bc. Inju			28d. Describe h		- ' '	,,	

To the Hospital or Attending P! within 24 hours effer death.

To the Funeral Director: After the completely filled in by the funeral

Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta and plece, end due to the cause(s) and mennar as steted.

2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted.

1 ☐ Yes 2 ☐ No

5 Pending investigation

6 Could not be determined

29c. Licansa number DIRECTOR, MEDICAL DISCOLOGY

28e. Plece of Injury - At homa, tarm, street, tectory, office building, etc. (Spacify)

29d. Date signed (Month, Dey, Year)
4 - 28 - 97

28f. Location (Street end Number or Rural Routa Number, City or Town, Stete)

State Registrar

Medical Certification

Neturel

2 Accident 3 Suicide

4 Homicide

29a. Certifier (Check only one)

6 Mis

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14520 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PATSY RUTH DIGGS April 30, 1997 7:55 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Home- 27334 Cash Corner Road Crisfield Somerset If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🕱 F 214-32-0660 Vrs 62 Director October 14, 1934 Maryland Usual Residence of Decedent with the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 la marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Somerset 1 ☐ Yes 2X No Director Crisfield 10e. Street and Number 10f Zip Code 10g. Citizen of What Counfry? 27334 Cash Corner Road 21817 U.S.A. death Funeral 14. Rece - American Indien, Bleck, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Peges 1 and 2 should be filed within 72 hours efter of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or item any injury or other traumatic event, the Medical Exempted ODGs. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 Yes 2X No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Grade 9 Packaging Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Clifton G. Taylor Mary A. Wilson 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hayes Diggs, Sr. (Husband) 27334 Cash Corner Rd. - Crisfield, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Sunnyridge Memorial Park 5/2/97 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crisfield, MD 21. Signature Pupiral Service Li 22. Name and Address of Fecility Robert Recherce Bradshaw & Sons Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 21817 Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) yest Comcer 9 mo Examiner Due to (or as a consequence of) Examiner ettending physician end for use as the buriel-trensit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of) Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the deteched 23b. Did tobacco use contributa to the causa of death? signed by t 2 No 3 Probably 4 ☐ Unknown 1 Yes þ 24b. Were autopsy findings Completed 24a. Was an autopsy peen available prior to completion of cause of death? performed' page 2 certificate hes 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Menner of Death 28d. Describe how injury occurred Certification:

certificete be exec Box 68760. Division of Vital Records, P.O. funerel After death. ne Hospital or Attendi n 24 hours after death. Ne Funeral Director: A

3altimore, Maryland 21215-0020

28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 Netural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

29e. Certifier (Check only one)

29b. Signature and title.

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) and manner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29c. License number 29d. Date signed (Month, Day, Year) 9

30. Name and address of who completed cause of death (Item 23e) (Type, Print)

pn A Grasso, M.D. - 145 E. Carroll St. - Salisbury, MD Joseph A 21801

Registrar

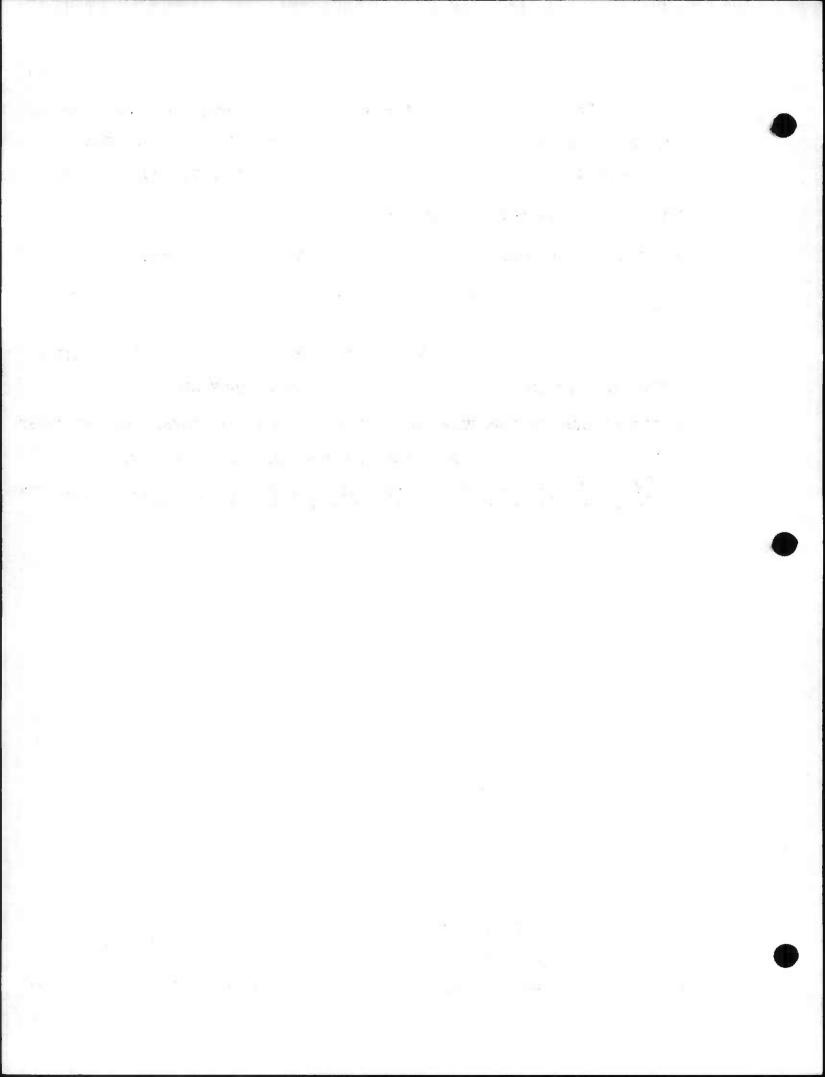
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To the Hosp within 24 hos To the Fune completely fi

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** FRANK DeRenzo APRIL 1997 9:00 AM 24. /Medical 4a. Fecility Nema (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WILLIAM HILL MANOR EASTON TALBOT | Months | Days | Hours | Min. | Max. 29, 1905 | NEW YORK 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign **Funeral** 1₩ 2□F Yrs. 122-26-3470 92 **Director** Uauai Rasidanca of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 23s-4 show enty injury or other traumatic event, the Medical Experimer must be notified at 10a. Stata 10c. City, Town or Location 10b. County 10d. inside City Limits MD TALBOT EASTON 1 Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 501 DUTCHMAN'S LANE 21601 USA Funeral 12. Was Dacedant Ever in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Spacify Yas or No-if Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Rece - American Indian, Black White atc 1 Nevar Married 2 Merried 1 ☐ Yas 2 ☐ No If Yas, GiveX X Baltimore. Maryland 21215-0020 1 ☐ Yes 2 XNo WHITE Specify: þ \$□Widowed 4 □ Divorced Year or Dates Completed 16a. Decedant's Usuai Occupetion (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decadant's Education (Specify only highest grade complated) 16b. Kind of Busineas/Industry Eiamantary/Secondary (0-12) Coliaga (1-4or 5+) POLICE OFFICER LAW ENFORCEMENT 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) VINCENT DERENZO MARIA ANGELUCCI 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) MARIE FERNANDEZ/ DAUGHTER 6718 EDGE RD., BOX 37, ROYAL OAK, MD 21662 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Deta 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramovel from Stete 4 ☐ Donation 5 ☐ Othar (Specify) WOODLAWN MEMORIAL PARK 4-26 EASTON, 21. Signaturesof Funarai Service Lice 22. Neme end Addrass of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 23a. Part1. Entar tha disaaaa, or complicationa to caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. 200 S. HARRISON ST., EASTON, MD 21601 Approximata intarvai Batween Onset and Death **Physician** /Medical immediata Causa (Final · LIPO SAROMA A BROMINAL disease or condition rasulting in death) Examiner Examiner MA SECONDAA!

Dua to (or as a consequence of): physician and the burial-transit Sequentielly list conditions, if any, laading to immadiata cause. Enter Undarfying Causa (Diseese or Injury that initiated events resulting in death) Last HYPER TENS 10 N
Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 98 attending for use signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 (LUnknown þ 24a. Was an autopay performed? 24b. Ware autopsy findings available prior to completion of cause of daath? Completed has 1 Yas 2 10 No 1 ☐ Yaa 2 ☐ No certificata 25. Was case referred to medical Be 26. Placa of Beath (Check only ona) examinar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Realdence 6 Other (Specify) P this funeral 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. injury at Work? 28d. Dascribe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After 5 Panding investigation 1 PNatural 1 □ Yas 2 □ No 2 Accident the 6 Could not be datamined 3 Sulcide 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) completely filled in by 4 Homicida edical 10 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated. 29a. Cartifier or: On the baus of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) and manner stated. 29b. Signature and titin of 29c. Licansa number 29d, Date signed (Month Day, Year) 11 MAKAS 30. Nama and addrass of person who complated causa of death (flem 23a) (Type, Print) MAKAS 508 IPLEUNCA DUE ASTON E. DANIEL 31. Date filed (Month, Day, Year) 32. Registrer'a Signatura State APR 2 8 1997 Theiden-Rendere Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** 5+eghe ~ 4e. Fecility Name (If not institution, give street end number) Month ELDER 2200 Mai /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 4108 Great Oak Road Rockville Montgomery 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. Hours Min. .Funeral 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) Deys 18 M 2□ F Hours 217-94-9722 Yrs Director 17,1962 Washington, D.C. Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Montgomery Maryland Rockville Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4108 Great Oak Road 20853 Funeral United States 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Raçe - Amarican Indisn, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 ☒ No If Yes, Give Yaer or Detas: 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Montgomery County Data Specialist 12 Government 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumeme) Be Richard O. Elder Edwina Duane 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health or Important: If item 27 is any Injury or other trau once. Edwina D. Elder/Mother 4108 Great Oak Road, Rockville, Maryland 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removel from Stete 5/6/97 4 Donatil 5/7 Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Sign ture of Funeral Service Licego 22. Name and Address of Facility Muriel H. Barber Funeral Home P.O. Box 5038, Laytonsville, Maryland 20882 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line. Immediate Ceuse (Finel Heart Jailure disaase or condition resulting in death) Tears Due to (or es e consequence of) Progeria Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequenca of): Physician/Medical Due to (or es e consequenca of): Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Be Completed by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 Yes 2 No 1 Yas 20 No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Deeth Certification: 28b. Time of

Examiner or Attending Physician: The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760. eftar deeth. Director: After this within 24 hours e To the Funeral D completaly filled Hospital

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Pages 1 and 2 should be filed within 72 hours after death with in ant of Heatth and Mantal Hygiane.
Int. If item 27 is marked other than "natural", or items 23a or?

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28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 SNeturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stata) 4 - Homicide 29e. Certifier

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the best of examinetion end/or investigetion, in my opinion, death occurred et the time, dete and place, end due to the ceuse(s) end menner steted. 29b. Signature end titla of certifier 29c. License number 29d. Data signed (Month, Dey, Yeer)

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30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) who

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State Registrar 31. Date lifed (Month, Day, Yeer) MAY 13 1997



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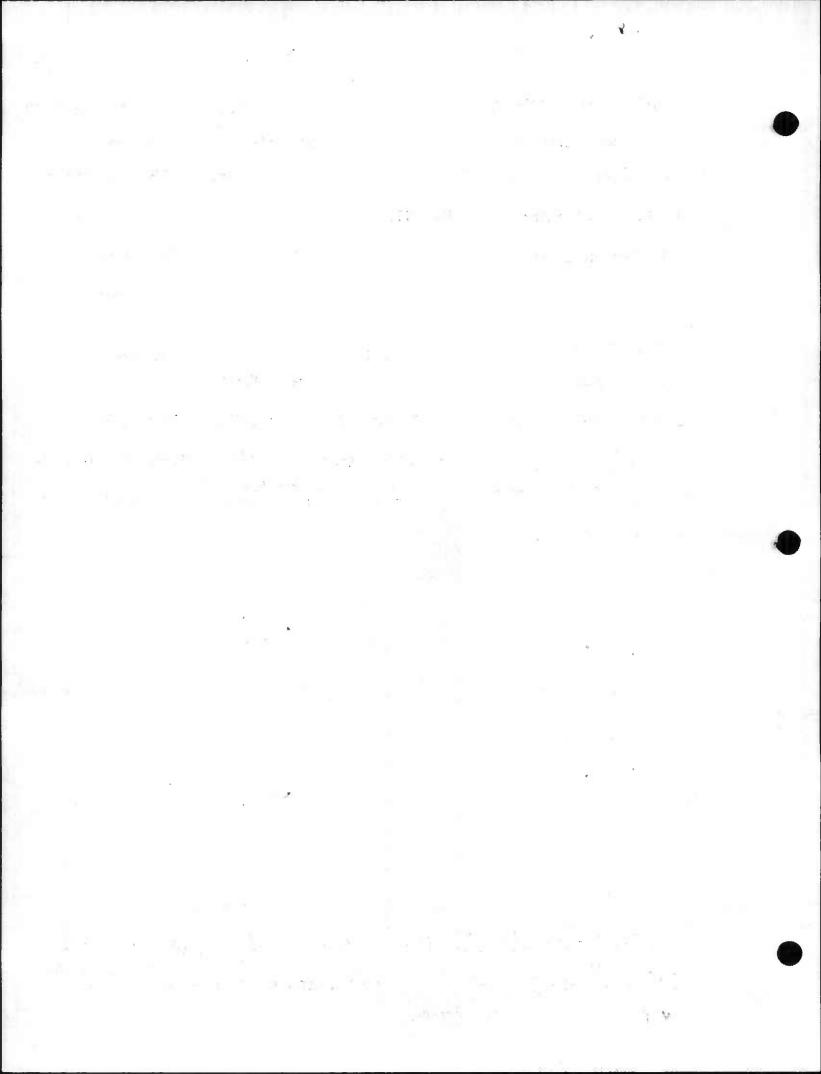
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** LOIS IRENE ESTELLE MAY 1997 11:35 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 624 Aster Boulevard Rockville Montgomery If Under 1 Year Months Deys 5. Sociel Security Number If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year)
Mar. 17,1934 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) New Jersey **Funeral** 10M 20 F Yrs 145-24-7801 Director 63 Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location show a notified at 10d. Inside City Limits Maryland Montgomery Rockville 1 X Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Hypiene. other than "natural" or thems 23e or ent, the Medical Examiner must be. 624 Aster Boulevard 20850 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marltel Stetus 14. Rece - American Indien, Pages 1 and 2 should be thed within 72 hours after nent of Health and Mental Hygiene. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 💢 No Specify: White þ rr Yes, Give Year or Detes: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 7 is marked of traumetic ev Edward Brown Helen Kolton 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zlp Code) nt of Health a : If item 27 is r or other tran Earl W. Estelle/Husband 624 Aster Blvd., Rockville, Maryland 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any injury or once. 5/6/97 4 □ Dopation 5 □ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Fecility
Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Maryland 20882 23a Part . Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one cause on each line. **Physician** Immediete Ceuse (Final diseese or condition resulting in deeth) /Medical **Examiner** Due to (or es e consequence of) Examiner ed by the attending physician end deteched for use as the buriel-trensit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by (1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evelleble prior to completion of cause of deeth? Completed 24e. Wes an eutopsy performed? hes certificate 1 ☐ Yes 2000 1 □ Yes 2 □ No director 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending investigation Naturel To the Hospital or Attendir within 24 hours efter death.
To the Funeral Director: Al completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signaffure and title obcertifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) MM 70 31. Dete filed (Month, Dey, Year) State MAY 13 1997 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 4524 Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth **Physician** 9: am Lionel Victor **EVANS** 26 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Undar 1 Yaar If Undar 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthpiece (State or Foreign Country) West Virginia 8. Date of Birth (Month, Dey, Year) **Funeral** 1⊠M 2□ F Months Deys Hours 232-09-3817 90 Director Dec. 24,1906 Usuel Residence of Decedent death with the Meryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits 12 Yes 2 No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 51 Elgin Blvd. 21740 U.S.A. 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours effer-tent of Health and Mental Hyglene. nt: If Item 27 Is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 No Baltimore, Maryland 21215-0020 white 1 ☐ Yes 2 HNo Specify: à 3 B Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) laborer builder of awnings traumatic event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meldan Sumema) Be Joseph Evans Sallie Howard 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. JoAnn Smith/Daughter 8126 Mapleville Road, Boonsboro, Maryland 21713 other 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete ò 1 Burial 2 □ Cremetion 3 □ Removet from State permit. Pege Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) Archers Chapel Cemetery Apr. 30, 1997 Tyler Co. WVA 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Interval Between Onset end Death Physician /Medical Immediate Cause (Final · Bilateral Preumonia disease or condition resulting in deeth) **Examiner** Due to (or es e consequence of): Examiner DEMENTIA. sician and buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest The law requires that the death certificete be execu physician s the buriel Division of Vital Records, P.O. Box 68760. ATHERBSCLEROTIC CARDID VASCULAR DISEASE. Physician/Medical Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 Yes 2 No 3 Probably 4 Unknown ò 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes an autopsy performed? 1 ☐ Yes 2 ☐ № certificate Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifica 25. Wes case referred to medical Be 26. Plece of Death (Check only one) exeminer? Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) NIA 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menger of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 28b. Time of NA 1 Neturet 5 Pending 1 Yes 2 No NAM 2 Accident investigation NA NIA 6 Could not be determined 3 Suicida 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to tha ceuse(s) end menner steted. To the I within 2 29b. Signeture end title of certifier 29c. License number 29d. Dete stgned (Month, Dey, Year) D 28365 4-26-97. 30. Neme end eddress of person who completed cause d death (Item 23e) (Type, Print) 368 MILL STREET HAGERSTOWN MID 21740. MANZAR J. SHAFI.

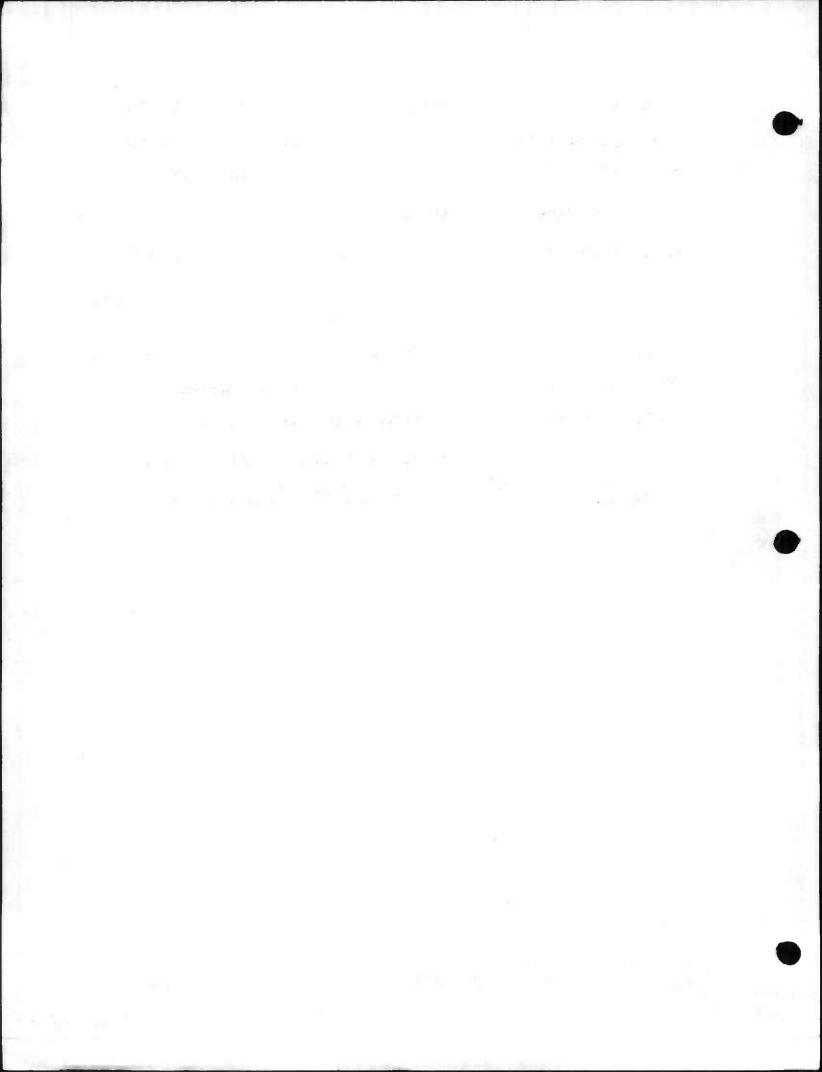
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	Funeral Director			Sax 7. A 1 □ M 2 □ F	ga (In yrs. lest		If Under 1 Year Months Days	If Undar 24 Hours	Min. (Mo	of Birth oth, Dey, Ye ot 9 19	930	9. Birthplac Country Maryl	ca (State or Foreign) and
	Maryland -I show	tor	10a. State 10b. County Md Allegar	ny	10c. City, To	own or Loca	ation					10d	Insida City Limits 1 Yas 2 □ No
	death with the Maryland ims 23a or 28a-f show frost te notified at	Funeral Director	10e. Street and Number 19208 Legislativ	re Rd.			10f. Zip Code 21521					What Country	?
020	or its	by	11. Marital Status 1 ☐ Never Marriad 2 ☑ Marriad 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forcas 1 Yes 2 If Yes, Give Year or Dates	? No	lf \	as Decedent of H Yes, specify Cuba	ispanic Orlgin n, Mexican, I	n? (Specify Ye Puerto Rican, e	s or No-	14. Rad Blad	e - American ok, White, ato	
21215-0020	within jene.	Completed	15. Decedent's E (Specify only highest or Elementary/Secondary (0-12) Unknown	ducation ede com <i>pleted)</i> College (1-4or		(Give ki life. DC	nt's Usual Occupind of work done of NOT use retired	ation du <i>ring</i> most o	of working			usiness/indus	
Maryland	s 1 and 2 should be filed within f Health end Mental Hygiene. Health end Mental Hygiene ltem 27 is marked other than other traumatic event, the Mental file Mental	To Be C	17. Father's Name (First, Middle, Last Sylvester Faze	enbaker				18. Mother's	J. SC	Middle, Meid	den Sumen		
	and 2 sho ealth end n 27 Is me		19a. Informant's Name/Relationship (Phyllis Fazenbak			1920	Address (Street) 8 Legisl						ode)
Baltimore,	8 = 5		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		ceme	tery, creme	tion (Name of story or other place ill Ceme		4-30-	97 Mos		Md.	n, Stata
Bal	permit. Pe Departmen Important: any injury		21. Signatura of Funeral Service Lice	Sml		Во	Name and Address al Funera 1 Church	al Hom	e 'esternp	ort, M	/d. 21	562	
	Physician /Medical Examiner)r	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finel disease or condition resulting in deeth)	plications that cause one cause on each	Due to (or as	eare	ingel	g, such as ca	rdiac or raspin	atory arrest,)	ln In	pproximate iterval Between inset end Death
68760,	ficete be executed physician and is the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events	b	Due to (or as								
Box 687	2 O 4	n/Medical	resulting in death) Last	d	Dua to (or as	a consequa	ince of):					1	
P.O. B	0 0 0	Physician/M	Part II. Other significant conditions of	0	out not resulting	in the und	erlying cause give	en in Part I.	23	^			ne cause of death?
	8 6 8	by	arterios	leg					248	1 Z Yes			autopsy findings
Records,	aw aw 2 s	Completed	5 mh se	ellysi	7					performed	?	of dee	ibia prior to letion of cause oth?
of Vital	Physician: The I this certificate ha	Be	25. Wes case referred to medical examiner?	Hamital					f Deeth (Check		21240		es ZLINO
Jou	는 문항	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospitel: 1 Inpati		Outpatient Time of Injury	3□ DOA Othe	4 LI NUIS	lng Home 54	Residence scribe how in			
Division	r Attendin ter death. rector: At	Certification:	1 🖾 Naturel 5 🗆 Pending investigation 3 🗆 Suicide 4 🗀 Homicide 6 🗀 Could not be determined	28e. Placa of In			M 1 🗆 '	Yes 2□No	28f. Loc	ation (Streat		er or Rural R	outa Number,
۵	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical Cer	(Uneck only 2 Medical Exam	yelclan: To the best	of my knowled	ge, death o	ccurred at the tim	e, date and p	olece, and due	to the cause	a(s) and ma	nner as state	ed.
	ro the ro the comple	Med	one) 29b. Signeture and title of certifier	end manner s	ated.		29c. Licansa					(Month, Day	
			Dun B	No.	10		012	235	1 -		4-2	8-9	7
		6	30. Nama and address of person who GRORGE DLEZ				DRIVE	CUM	1BER4	LND	MD		
	Sta Registr		31. Data filed (Month, Dey, Year)	32. Regist	rar's Signatura	P	1 10:					E	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

14526

Physici /Medic Examin	al
Funerai Director	

permit. Peges 1 and 2 should be lifed within 72 hours after deeth with the Meryland Department of Heelth end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

Physic /Medi Exam

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after deeth.

To the Funerial Pictors After this certificate has been signed by the attending physician and completed thinks to the forest discount and complete the second of the second physician and complete the second of the

Division of Vital Records, P.O. Box 68760,

	Decedent's Neme (First, Middle,)	Last)					2. Dete of Dec		Veer	3. Tim U th
iar ca	James Milt	on	Fletc	her			April 2	28, ^{Dey} 1997	7 Year	6:45 AM
ei	4 a Facility blome (If not leadly then	nive street and number)			4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth	
	2701 Park Heigh				William	Baldwin	_	Hari	_	
	5. Sociel Security Number 216–28–3818 Usuel Residence of Decedent	Sex 7. A	ge (In yrs. last 78	Yrs.	Months Deys		8. Dete of Birt (Month, De Feb. 14	1, 1919	9. Birthp Cour Mary	plece (State or Foreign ntry) Land
	10a. Stete 10b. County		10c. City, T	own or Loc	ation				1	10d. Inside City Limits
	Maryland Harf	ord	Ba	aldwir	1					1 ☐ Yes 2 🕱 No
	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Cour	ntry?
					2101	3		USA		
	11. Meritel Stetus	12. Wes Decedent Armed Forces	?	13. W	es Decedent of I Yes, specify Cub	Hispanic Origin? (Sp en, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ca - Americ ck, White,	can Indian, etc.
	3 ☐ Widowed 4 ☐ Divorced	f Yes 2 ☐ If Yes, Give Yeer or Detes:	WW II	11	□Yes 2½ No	Specify:		Specif	w Whi	.te
	15. Decedent's (Specify only highest of Elementery/Secondary (0-12)		1	(Give k	nt's Usuel Occu ind of work done	during most of work	ring	16b. Kind of B	usiness/In	dustry
	Elementery/Secondary (0-12)	College (1-4or 2	5+)	1110. De	O NOT use retire Servi	*		Pump &	Comp	ressors
		st)				18. Mother's Nam	e (First, Middle,	-	- 1	1000010
		cher				Hilda T	hompson			
	19e. Informent's Neme/Relationship	(Type, Print)	-1	19b. Mailing	Address (Street	t end Number or Rur	al Route Numbe	r, City or Town	, Stete, Zip	Code)
	Vivian I. Fletc	her (wife)	2005 Plane	2701 F	ark Hei	ghts Driv				
	20e. Method of Disposition **Documentarian 2 Cremetion 3		ceme	etery, creme	story or other ple	oce)	/30	Abordo		own, State Maryland
	4 Donetion 5 Other (Special Signature of Funeral Service Lice		200101		Neme end Addre		, 50	Aberde	sil, Pi	aryrana
	Ki Non Any	1/100/0	MOD	Ta	rring-Ca	argo Funei	cal Home	P.A.		
	23a. Pert1. Enter the disease, or co	piplications that cause	d the deeth. D			Maryland Ing. such es cardiec				Approximete
	shock, or heert failure. List on	y one cause on each i	ine.						1	Onset and Deeth
	Immediate Cause (Final disease or condition resulting in death)	· ADENOC	ARCI	NOM	2 UNIC	NOWN P	SAMI	N		78 DAVIS
	1	100								
		b	Due to fee on				/		- 1	•
	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or es	e consequ	ence or):		/			
	that initieted events resulting in deeth) Lest	C. ————	Due to (or es	e conseque	ence of):					
		d							1	
							1			
	Pert II. Other significant conditions	contributing to death b	out not resulting	g in the und	lerlying cause gi	ven in Pert I.		obacco use co res 2□ No		o the cause of death? bebly 4 □ Unknown
							ישי	165 2LINO	3 Pro	bebly 4 Onknow
							24a. Wes	an eutopsy med?	av	ere autopsy findings railable prior to
									of	empletion of cause deeth?
							1 🗆 Y	es 20 No	10	□Yes 2□No
	25. Wes case referred to medical exeminer?	Hospitei:			Out	26. Place of Deet	h (Check only o	10)		
	1 Yes 2 No	1 ☐ Inpation		Outpatient	3LI DOA		me 5 Resid			(צי
	1 Naturel 5 Pending	(Month, Da	y Year)	b. Time of Injury	28c. inju Wo M 1	rk? IYes 2 □ No	28d. Describe h	ow injury occur	red	
	3 Suicide 6 Could not determine	d 28e. Piece of in	ury - At home,	farm, stree	et, fectory, office		28f. Location (S	treet and Numb	per or Rura	al Route Number,
	4 El Tolliodo	. building, et	c. (Specify)				City or Tow	n, Siele)		
	29a. Certifier 12 Certifying P	hysician: To the best miner: On the basis of and manner st	examinetion	ige, deeth o end/or inve	occurred at the til stigation, in my o	me, dete end plece, opinion, deeth occurr	end due to the or red et the time, o	euse(s) end me lete end plece,	end due to	teted. o the ceuse(s)
•	29b. Signature and title of certifler	1 /		/	29c. Licens	se number		29d. Dete signe	d (Month,	Day, Year)
	May	4		Λ	D	131773	>	4	-29	- 47
	30. Name and address of person who	completed cause of d	leeth (Item 23)	a) (Type, Pi	int) A	10.	-	,	1 1	2 10110
	JI Dale Hed (Month, Day, Year)	DSM.D	arts Signeture	2 B	ELITT	RKD	DU	4STO	V /[]	D 21047
e	The state of the s		alia d'au		ardik.					
	ALM TO THE PARTY OF									

DHMH 16 Rev 6/95

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month HELEN LEE 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Genesis Eldercare Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) Deys 1 M 2 X F 227-07-4076 Yrs 81 Sept 1,1915 Virginia Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21122 USA 444 Park Creek Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, 2 XNo If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 Assembly Worker Bendix 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Sumeme) Robert Painter Lee Bessie Du 1 1 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Deanna Feehley/daughter 444 Park Creek Rd., Pasadena, MD 21122 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) May 1 20c. Location - City or Town, Stete 1 ☑ Burlal 2 ☐ Cremetion 3 ☐ Removel from State Staunton, Thornrose Cemetery VA 4 ☐ Donetion 5 ☐ Other (Specify) 1997 Barranco & Sons, 21. Signeture of Funerel Service Licensee Home P.A. Severna Park Funeral / Soluto 495 GovRitchie Hwy., Severna Park, MD 21146 23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth Immediete Ceuse (Finel ARTERIOSCUENTIC CARDIOVASCULAR diseese or condition resulting in death) TEAMS DISBASE Due to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobacco use contributs to the cause of death? 1 Yas 2 No 3 Probably 4 Dunknown DIABBTES

Physician /Medical Examiner

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certificate

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After

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To the Hospital o within 24 hours of To the Funeral Di completely filled in

in by the funeral

Physician/Medical

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Completed

Be

10

Certification:

Medical

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital

Division

Attending Physician:

ò

Physician

/Medicai

Examiner

10e. Stete

,Funeral

Director

28a-f show

6

items 23a

permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Manical Engaries any injury or other traumatic event, the Manical Engaries.

death

21215-0020

Baltimore, Maryland

Examiner must be notified at

Director

Completed by

Be

Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

ATRIAL ABRILLATION

24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 LNG 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medical examiner? 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Menner of Deeth 1 Waturel 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work?

28d. Describe how Injury occurred 1 TYes 2 No

29a, Certifier (Check only

4 Homicide

31. Dete filed (Month

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and little of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

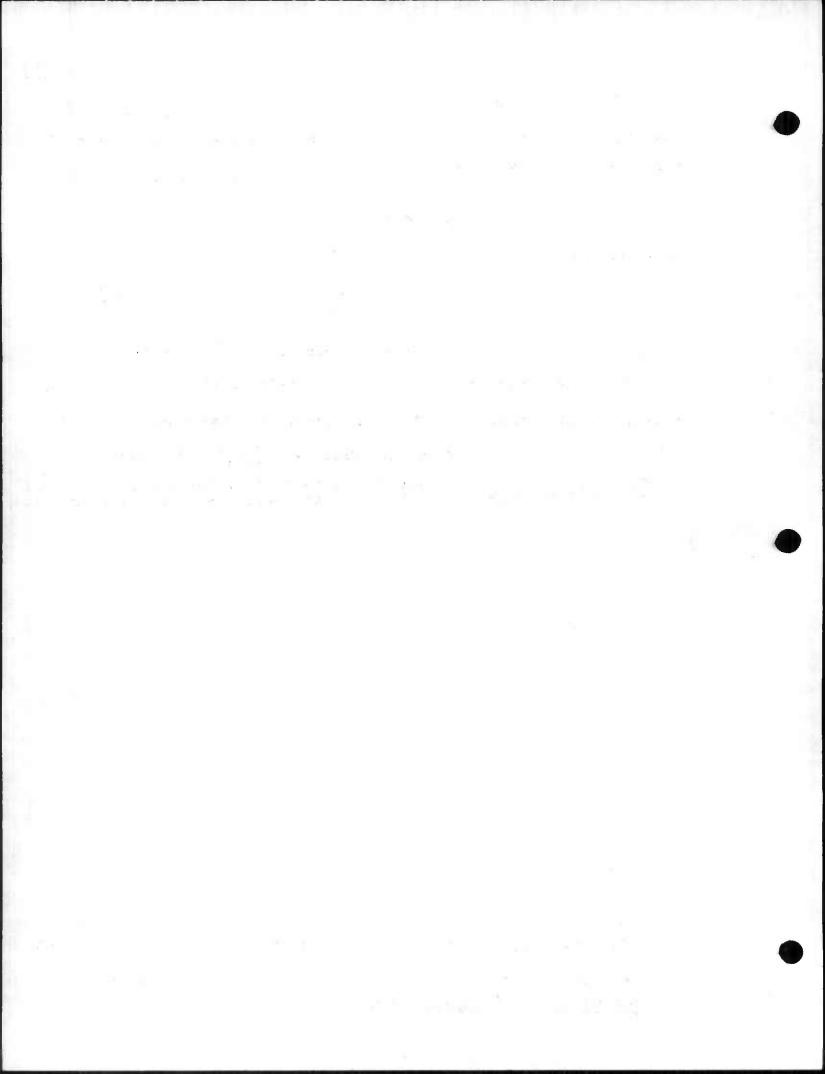
Phetre

21776

APRIL 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SULYA MWNSRA Mp 8109 R17 Chile HI6Hwn

State Registrar 32. Hegistrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14528 Certificate of Death 1. Dacedant's Name (First, Middle, Last) 2. Dete of Daath 3. Tima of Death Month Dav **Physician** ESTHER ANNIE APRIL FARRELL 29 /Medicai 1997 2:40 P.M. 4e. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY if Undar 24 Hrs. Hours Min. If Undar 1 Yaar 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funerai** 8. Date of Birth (Month, Day, Year) Birthpiaca (Stata or Foreign Country) Days Months 1 □ M 20XF 215-12-2353 Director 78 MARYLAND Usuel Rasidanca of Decedant with the Maryland 10a. Stata 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits must be notified at Director XX Yas 2 No MARYLAND ALLEGANY MT. SAVAGE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6 238 12906 NEW ROW STREET death 21545 U.S.A. Funeral items! 12. Wes Decedant Evar in U,S. Armed Forcas? 11. Marital Status Was Dacadant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American indian, Black, Whita, atc. Peges 1 and 2 should be filed within 72 hours efter nent of Health end Mental Hygiena. int: if Item 27 is marked other than "natural", or ite 1 Navar Married 2 Married ☐ Yas 2 X No Yas, Giva altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: WHITE 3 ₩idowed 4 Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decadant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Sacondary (0-12) College (1-4or 5+) 10 HOUSE KEEPER HOUSE KEEPER 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be WILLIAM H. CANTY 2 BESSIE BAHR 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) DAUGHTER 12908 NEW ROW STREET MT. SAVAGE, MARYLAND 21545 LINDA C. TRIMBLE other 20a, Mathod of Disposition 20b. Placa of Disposition (Nama of 20c. Location - City or Town, Stata permit. Peges
Department of I
Important: If Ite
any Injury or ot ST PATRICKS CEMETERY MAY 1 1 Burial 2 □ Cremetion 3 □ Ramoval from Stata 1997 MT SAVAGE, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Lice 22. Name and Addrass of Facility MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND Part 1. Entar the diseasa, or complications that caused tha daath. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Batween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Exacerbation of chronic obstructive lung disease 4 days Examiner Due to (or as a consequanca of): Examiner The law requires that the death certificate be executed buriel-tran Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Causa (Disaasa or injury thet initiated events rasulting In daeth) Last Dua to (or as a consequanca of): P.O. Box 68760, physicien s the bune Physician/Medical Dua to (or as a consequanca of): 88 etten signed by the et Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Lung cancer Records. by page 2 should Completed 24a. Was an autopsy performed? 24b. Wara autopsy tindings available prior to completion of cause of death? certificata 1 🗆 Yas 2 No of Vital Hospital or Attending Physician: director. Be 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) 2 No Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yas Certification: To this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 2 ☐ Accident 5 Pending investigation Injury To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: After completely filled in by the furnity and the furnity of the formula 1 Yas 2 No 3 Suicide 6 ☐ Could not be determined 28e. Pieca of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 | Homicida 📉 Certifying Physician: To tha best of my knowledge, daath occurred at the time, data and place, and due to the causa(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mennar stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

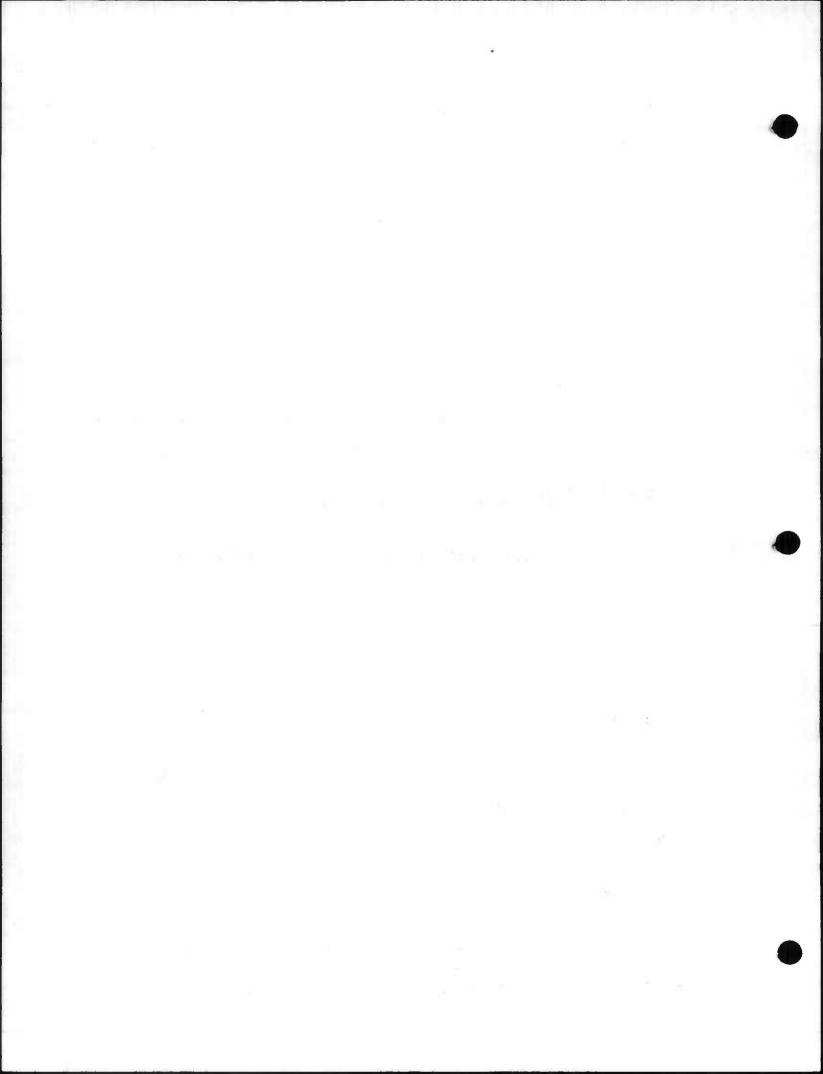
D 35481

State Registrar 31. Date filed (Month,

30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

Mark Sagin M.D. Memorial Hospital Cumberland, MD 21502

Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14529 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Deeth **Physician** Month Askins-GRIFFIN APR:1 Clementine MildRed 1997 28 /Medical 40. County of Deeth 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Hospital Carver. In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Defa of Birth Devs Hours Min. (Month, Dev.) General Dorchester Dorchester 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) 6. Sex **Funeral** 1 M 210 F Year) 81 Director 1915 220-10-6170 Maryland Usual Residence of Decedent the Maryland 10e. State 10b County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Examiner must be notified at 1 PYes 2 □ No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter death with igh Street 21613 U.S. A Completed by Funeral 1012 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married 1□ Yes 21 No Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede com 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Beautician ENTREPRENEUR Pages 1 end 2 should be filed venent of Health end Mental Hygie int: if item 27 is marked other t 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumeme) James Chauncell ASKINS Depeu Olivia Sampson 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) GRIFFIN 7430 Sweet Clover 20b. Piece of Disposition (Name of cametery, crametory or other place) Department of Health er Important: if item 27 is any injury or other trau Columbia, Maryland 20c. Location - City or Town, Stete DeRRICK 20a. Method of Disposition Date 1 DBuriel 2 □ Cremation 3 □ Removal from State Mount Zion Cemetery 5/3/97 East New Market, IND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nama end Address of Fecility Henry FUNERAL 21613 23e. Part J. Effer the disease, or complications that caused the disth. Do not enter the mode of dying, such es cardiac or respiretory errest, Approximate Approximate Interval Batween Onaet and Deeth **Physician** /Medical tmmediate Ceuse (Final MULL disease or condition resulting in death) **Examiner** Sequantially list conditions, if eny, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Lest Due to (or as e consequence of): Physician/Medical Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 3 No 3 Probably 4 Unknown POISIEN/ þ 24b. Were autopsy findings aveileble prior to completion of ceuse of death? Completed 24e. Was an autopsy performed? CHOCK TROTEMIA 2 XNO 1 ☐ Yes 2 No After this certificate Be 25. Was casa rafarrad to medicel 26. Placa of Death (Check only one) examinar 2 1 Yas 2 No Other: 4 Nunsing Homa 1 Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 5 ☐ Rasidence 6 ☐ Othar (Specify) filled in by the funeral 27. Mannar of Deeth 28c. Injury et Work? Certification: 28b. Tima of 28d. Describe how Injury occurred 1/17 5 Panding investigation Natural 2 Accident death. 1 Yes or Attend efter death Director: / 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicide

Attending Physician: The law requires thet the death certificate be executed P.O. Box 68760, Division of Vital Records, To the Hospital o within 24 hours eff To the Funeral Di completely filled in

21215-0020

Baltimore, Maryland

State Registrar

edical

29e. Ceptiller

(Check only

290. Signature and title of adritit

31. Datefiled (Month, Day, Year)

WE

123 Win Stevelson Rardall

use of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and pieca, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, daeth occurred at tha tima, data and place, end dua to the causa(s)

29c. License number

050271

MUR ST CAMBRUNCE

29d. Date signed (Month, Dey, Yeer)

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2021

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland	Dep	artme	ent o	f H	ealth	and	Mental	Hygien	e
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9	7	1	12.	5	3	0
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Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Haalth and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23e or 28e4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the bunal-transit

Division of Vital Records, P.O. Box 68760,

				Cerun	icale	UI I	Dealli			Reg. !	No.		1?.	000
cian dical	1. Decedent's Neme (First, Midd. Steve	· ·	G i 11 2nd						2. Dete of D April		9th	1997		ne of Deeth = 55Hrs
niner	4a. Fecility Neme (If not institution	n, give street end numb	er)				4b. City, To	wn, or L	ocation of Dea	th .	4c. County	of Deeth		7.5
	Beaver Dam	Road						Abir	ngdon	Harfor			ord	
al	5. Sociel Security Number		Age (in yrs. lest birtl		U 1			24 Hrs.	8. Dete of B (Month, D	irth	1			ete or Foreign
r.	375-82-0211	11XM 2□F	26 Y	rs.	onths E	eys	Hours	Min.	Dec. 2					
	Usuei Residence of Decedent										1370	TILCI.	цуа	11
	10e. Stete 10b. County		10c. City, Town	or Location	on		10d. Inside C							de City Limits
Ş	Maryland	Harford				P	bingd	lon					1 🗆	Yes 2☑ No
Director	10e. Street and Number			1	Of. Zip Co	de				10g. (Citizen of	Whet Count	ry?	
<u>=</u>	653 North Br	anch Court					21	1009				USA		
Funerai	11. Merital Stetus	12. Wes Decede		13. Wes	Deceden	t of H	lispenic Ori	igin? (Sp	ecify Yes or N Rican, etc.)	0-		e - America		n,
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by	3 Widowed 4 Divorced	if Yes, Give Yeer or Dete	s: 1993-95	10	Yes 2D	LNo	Specify:				Specif	Whit	e	
Completed	15. Deceder	nt's Education	16e.	Decedent'	's Usuel C	ccup	etion	4 0 4	1	16b.	Kind of B	usiness/Ind	ustry	
ple	Elementery/Secondary (0-12)	st grade completed) College (1-4d		(Give kind of work done during most of working life. DO NOT use retired)										
5		3			t				St	udent				
Be (17. Father's Neme (First, Middle,	Last)			18. Mothe	er's Nem	e (First, Middle	e, Meid	en Sumen	ne)				
To	Steven Ly	nn Gill		Maureen Anne Parent										
1	19e. Informent's Neme/Reletions								al Route Num					
	Karen M. Ricke	Court	, Abin	gdo	n, Ma	rylan	d	21009						
	20e. Method of Disposition		20b. Pleca of	Dispositio	n (Neme	of r pled	ce)		Dete	20c.	Location -	City or Tov	vn, Stel	0
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ė	21. Signatula di Funeral Service			22. Ne	me end A	ddre	ss of Fecili	tv						
	Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009													
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest.													21009 imete
	shock, or heart feilure. List	only one cause on each	h line.	or ornor tr	10 111000 0	. ayıı	19, 0001100	ourdioo	or reapiretory	011001			Interval	Between and Deeth
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la la	Due to (or es e consequence of):													
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хаг	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of):													
	Cause (Disease or injury	с										i		
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n/Medical		d												
ciar														
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Completed by									04. 146.	G W		0.4h 18/a		and the steam
ete									24a. We per	ormed		ava	ilable p	psy findings rior to r of cause
ldu												of d	eath?	01 04430
S									1 🗆	Yes	No No	10	Yes -	2X) No
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Ë	27. Menner of Death 1 □ Neturel 5 □ Pendir	28a. Dete of la (Month, I	njury 28b. Ti	ime of	28c.	injur Wor	y at		28d. Describe	how in	jury occur	GSW	0.0	ontact
atic	2 ☐ Accident investi	getion / 28 /			М		Yes 🏖		410 C	4 4 4 3 T T	ber	Head		meace
tific	3 ASulcide 6 Could 4 Homicide determ	not be inned 28e. Plece of building	4-28-4-29-97 NK 28e. Piece of injury - At home, farm, street, fectory, offica building, etc. (Specify) Field at the end of Beavar DAM RD Sethtlicted 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)										Num <i>ber</i> ,	
Certification:		Field	at the	end	o f	Ве	eav^r	· DA		,,,, O.,	,			
Ca	29a. Certifier 1 Certifyin	g Physician: To the be	st of my knowledge,	deeth occ	curred et t	he tin	ne, dete en	d place,	and due to the	cause	(s) and me	anner as sta	ited.	
Medical	one) 21.1 Medical	Examiner: On the basis and menner	steted.	vor investi	yellon, in	my o	pinion, dee	un occur	emit ent se per	, gete (па рівсе,	and due to	tne cau	150(S)
×	29b. Signeture and title of certifie	()	A		29c. L	cens	e number			29d. [Dete signe	d (Month, D	ay, Ye	ar)
	yours	my m	DME			00	CME			A	ril	29 th	19	97
	30. Neme end eddress of person	who completed cause of	deeth (Item 23e) (1	Type, Print	t)									
		1810	Belair H			to	n MI). 2	1047	410	-879	-656	4	
tate	31. Dete filed (Month, Dey, Year)	. D .	strenis Signeture	TO STANDON										

32. Registrens Signeture

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State Registrar

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State of Maryland / Department of Health and Mental Hygiene

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Physician	
/Medical	
Examiner	

Funeral Director

filed within 72 hours after death with the Maryland rai', or items 23a or 28a-f show Examiner must be notified at 'natural', or I Hygiene. other than "natural ent, the Medical E Pagas 1 end 2 should be 1 nent of Health end Mentel 27 is marked or traumatic even

Saltimore, Maryland 21215-0020

Physician /Medical Examiner

nt of Health e if item 27 is or other tra

parmit. Paga Department of Important: If any injury or

sician and buriel-transit The lew requires that the death certificate be axecuted P.O. Box 68760. the for use as signed by t Records, page 2 should hes carlificate of Vital director. After this Division

To the Hospital or Attending Physician: illed in by the funeral s aftar death. within 24 hours a completaly

Certificate of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2 Date of Deeth RUTH GLASS 2:36 PM April 1997 26 le. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital & Medical Center Cumberland Allegany If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Undar 1 Yaar Birthplece (Stete or Foreign Country)
 MARYLAND Deys Months 1□ M 2√2 F 217-42-6240 89 Yrs. Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director MARYLAND ALLEGANY LAVALE 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11 CASH VALLEY ROAD 21502 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Bace - American Indien. Bleck, White, etc. Yes 2)(No Yes, Give 1 ☐ Naver Married 2 ☐ Married 1 ☐ Yes 2X No Specify: WHITE Specify: Be Completed by 3 □ Widowed 4 □ Divorced Year or Detes 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 HOUSE KEEPER HOUSE KEEPER 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maidan Surneme) Laura Willard Deffenbaugh Harry Levi Robison 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) SON 12406 GRAMLICH ROAD LAVALE, MARYLAND WALTER C. GLASS 20b. Piece of Disposition (Neme of 20a. Method of Disposition Dete 20c. Location - City or Town, Stata cemetery, cremetory or other place) 1 Buriel 2 Cremetion 3 Removel from Steta
4 Donetion 5 Other (Specify) ROSE HILL CEMETERY APRIL 29 1997 CUMBERLAND MARYLAND 21. Signature of Fugerel Service 22 Name end Address of Facility MERRITT-ADAMS FUNERAL HOME einl α 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Perf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediete Ceusa (Final Ruptured duodenal ulcer with peritonitis disease or condition resulting in death) 1 day Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medicai Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy 2 0 No 1 Yes 1 Yas 2 No Be 25. Wes cese referred to madical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 Inpatient 2 ER/Outpatiant 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 - Homicide Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the ceuse(s) end menner as steted. Medicai 29e. Certifier Medical Examiner: On the best of my knowledge, deed occurred at the time, date end place, and due to the ceuse(s) and menner steted. (Check only one) 29b. Signeture en title of confine 29c. License number 29d. Dete signed (Month, Dey, Year) D 12779 1997 April 30. Neme end addressed mb completed ceuse of deeth (Item 23a) (Type, Print)

Memorial Hospital Medical Building

32. Registrer's Signeture

Cumberland, Md. 21502

State Registrar Dr. Fiscus

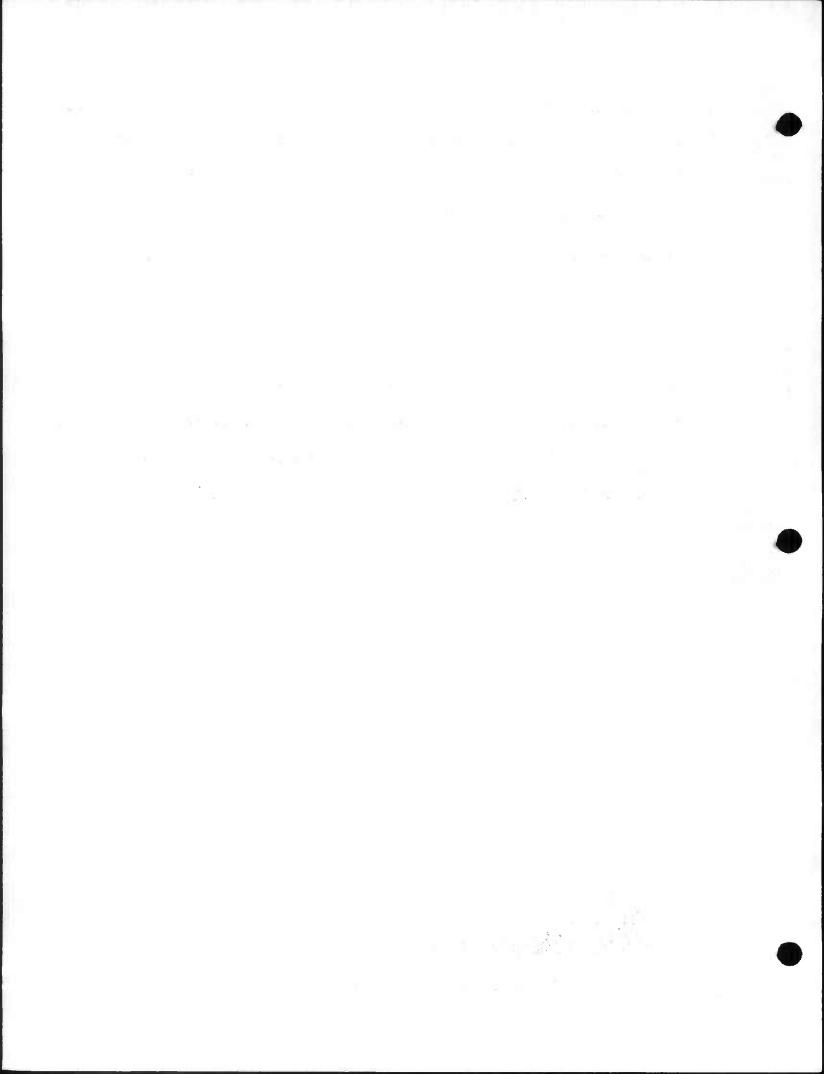
31. Dete filed (Month, Dev. Year)

State of Maryland / Department of Health and Mental Hygiene

97 14532

						Cen	tificate of	Death		Reg. No.	01	1 4 0 0 6			
			1. Decedant's Nama (First, Middla, Last)					2. Data of I	Death	Vess	3. Tima of Death			
	Physic /Medi		PAUL BRANT GLE	SSNER					APRIL	28 Day	1997	6:00 PM			
	Exami		4a. Facility Nama (If not institution, giva	street and number)				4b. City, Tow	n, or Location of De	ath 4c. Co	unty of Death				
1			APT# 110 Frostbur	g Heights	APTS			FROSTB	URG	AL	LEGANY				
	Funeral Director		5. Social Security Number 210-07-8528 Usuel Rasidance of Decedant	X 7. Aga	(In yrs. las	Yrs.	if Undar 1 Yaa Months Days		Min. (Month, I	Birth Da <i>y, Year)</i> R 14 1	9. Birth Cou	placa (Stata or Foraign ntry) Pa .			
	and w		10a. Stata 10b. County		10c. City,	Town or Loc	ation			10d. inside City					
	Se-f sh	ctor	MARYLAND ALLEGAN	Υ	FRO	STBURG	3					1 Yas 2 No			
	1 to 8	급	10e. Street and Number				10f. Zip Coda			10g. Citizan	of What Cou	ntry?			
	eth w	ā	100 Honeysuckle La				2153			U.S.					
Maryland 21215-0020	s 1 and 2 should be filed within 72 hours after death with the Meryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Navar Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant E Armed Forcas? 1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas:		If	/as Dacedant of Yas, specify Cu ☐ Yas 2⊠ No	ban, Maxican,	n? (Specify Yas or I Puarto Rican, atc.)		Raca - Amari Black, Whita, ecify: Wh:				
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7	12 should be and Mental is marked o raumatic eve	P		3.		essner		Ali			ant				
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e,	other tr		Anna Ruth Glessner 20a. Mathod of Disposition		-		neysuck. Ition (Nama of	Le Lane	Apt. 110	T	burg, I				
٥	Pages nent of } ant: If ite		P☐ Burial 2 ☐ Cramation 3 ☐ F	Ramoval from Stata	cem	atary, cram	atory or other pl		Data		,				
	t. Partmer		4 □ Donation 5 □ Othar (Specify)		Rocky				.May2,199	7 Flint	tstone,	Md.			
Baltimore,	permit. Pages Department of Important: If it any injury or one.		21. Signature of Funaral Sarvice Licens	aa			Nama and Add		Funeral H	ome					
	40240		Merritt-Adams Funeral Home 404 Decatur St. Cumberland, Md. 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, interval Batween interval Batween												
ST.	Physician		23a. Part1. Entar tha disaasa, or compi shock, or haart failura. List only or	ications that causad t na causa on aach line	ha daath.	Do not anta	r tha moda of dy	ring, such as ca	ardiac or raspiratory	arrast,		Approximata Intarval Batween Onsat and Death			
	/Medical Examiner		Immadieta Causa (Final disaesa or condition rasulting in death)	a	·	onary	Arrest					∠ 1 year			
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	aeth certificate be executed attending physician end for use as the burial-transit	Examiner	Sequantially list conditions,	D1		s a consequ		.003 110	111005						
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×	ding p	3		d					11	///					
8	attend for us	Sian							(0)		APN 28	(1957			
o.	the de	Physician	Part II. Other significant conditions cor	ntributing to death but	not rasultin	ng in tha und	derlying causa g	ivan in Part i.	23h. Di	d tobacco use	e contribute t	o the cause of death?			
۵,	that the deeth hed by the atter	by Ph							1[Yes 2€	No 3□ Pro	bably 4 Unknown			
Records,	aw requires that the deeth is been signed by the atter 2 should be deteched for t	Completed b					<u>-</u>			as an autopsy formed?	av	dara autopsy findings railable prior to emplation of causa daath?			
	e de	E							10	Yas 200	to 1	□ Yas 2□ No			
<u> </u>		Bec	25. Was casa referred to medical examinar?					26. Placa d	of Death (Check only						
_	5 00	To	1 A Yas 2 No	lospital: 1 ☐ inpatian	2 🗆 ER	VOutpatient	3□ DOA O	ther: 4 Nurs	ing Homa 5 Ra	sidance 6	Othar (Special	fy)			
ouo	e the		27. Mannar of Deeth Natural 2 Accidant S □ Pending investigation	28e. Deta of Injury (Month, Dey	Year) 28	Bb. Time of Injury	28c. Inj W	uryat ork?]Yes 2 ☐ No		e how injury o	ccurred				
Division of Vital	of or Attend a after death I Director:	Certification:	3 Suicida 6 Could not be detarmined	28a. Place of Injur building, atc.		a, farm, strad	at, factory, office		28f. Location City or 7	(Street and Nown, State)	lumber or Run	al Routa Number,			
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f	edical C	29a. Cartifiar (Check only one) Certifying Physical Cartifian	sician: To the best of nar: On the basis of a and mannar state	xamination	odge, deeth on and/or inva	occurred at that astigation, in my	ime, dete and opinion, daath	place, and dua to the	a cause(s) en a, data and pia	d menner es s aca, and dua t	steted. o tha causa(s)			
	Vithir To the	Me	29b. Signature and time of certifier -	11.	n		29c. Licar	nsa number		29d. Data s	igned (Month,	Day, Year)			
	7		> Monal	Mumm 1	1/20)	D 1	16041		APRIL :	29 1997	7			
	has		30. Nama and addrass of person who co	emplated cause of dea	eth (Item 2	3e) (Type. P	rint)								
	1463		DR. TERRY WILLIAM					AL BIITL	DING CUMB	ERI.AND	MARYI	AND 21502			
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Registrar



State of Maryland / Department of Health and Mental Hygiene 97

97 14533

						Certifica	te of	Death		Reg. No.			
			1. Decedant's Nama (First, Middla, La	ist)					2. Data of D	Peath		3. Tim	a of Death
	Physic		James L. C	S-Ormer,	Sn.				Month	Day 4	Yaar 997	12!	40 P.M.
2.0	/Medi Exami		4a. Facility Nama (If not institution, give					4b. City, Town	, or Location of Dea		ty of Death	/	10111
٢	- LAGIIII		MARIAGINIA	Haspital				Crisal	penlaud		ryla		
-	Funeral		Memorial 1 5. Social Sacurity Number 8. S	Sax 7. Aga	(In yrs. last bir			r If Undar 24	Hrs. 8. Data of E	lirth Day, Year)	9. Birthr	placa (Sta	ta or Foraign
	Director		220-10-7193	18 M 2□F		Yrs. Month:	Days	Hours	Min. (Month, L	Day, Year) -6,1916	Coul	ntry)	1-1-1
			Usual Rasidance of Decedant		00				Dr.	6,1710	114	ary	900
	ylen Mor		10a. Stata 10b. County		10c. City, Town	n or Location					1	10d. Insida	a City Limits
	Mar Mar	to	Maryland Allega	NY	CUM	berlai	vd					1701	Yas 2□No
	1 the	Director	10e. Street and Numbar				ip Coda	(10g. Citizan of	What Cour	ntry?	
	3a o		534 North C	ontre st	CPOT		21	502		US	A		
	fter death with the Marylen I fems 23a or 28a-f ehow iner must be notified at	era	11. Marital Status	12. Was Dacedant E		13. Was Dec			n? (Specify Yas or N		ce - Amaric	can Indian	1.
0	72 hours after death with the Maryland natural; or items 23a or 28a-f show steal Examiner must be notified at	Funeral	1 Nevar Married 2 Married	Armed Forcas?		it Yas, sp	ecify Cu	ban, Maxican, F	n? (Specify Yas or No Puarto Rican, atc.)	Bla	ack, Whita,	atc.	
20	irs aft	þ	3 ☐ Widowad 4 ☐ Divorced	1 X Yas 2 ☐ No If Yas, Giva Yaar or Datas: ∠	UWII	1 Yas	2 1 No	Specify:		Speci	ity: wh	hite	5
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21215-0020	nin 7.	Completed	(Specify only highast gra	· · · · · · · · · · · · · · · · · · ·		(Giva kind of w lifa. DO NOT	rork don:	a during most o	f working				
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Maryland	A P P S	To Be	George Go	N 44 000				50	iraH h	1:70			
Š	d 2 should th and Men 7 le marke traumatic	F	19a. Intormani's Name/Ralationship (19b	Malling Addra	ss (Stres		or Rural Routa Num		n State Zir	n Code)	
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Bal	permit. Page: Department of Important: If I any Injury or once.		21. Signature of Funaral Sarvice Licer		1	22. Nama :	and Add	Sterwin	7,1997 INC: 230	Dalt1	More	PAU	PNUE
	00200			7. Rileg. /	r	CUML	sen i	land.	md, 21	502			
П			23a. Part1. Entar tha diseasa, or com shock, or haart failura. List only	plications that caused to ona causa on each line	ha death. Do r	not antar tha mo	oda of dy	Ing, such as ce	ordiac or raspiratory	arrest,		Approxi	mata Between
ā	Physician											Onsat a	nd Death
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П	Examiner		rasulting In daath)			consequance of		00	29 0/3	771		10	
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	e death certificate be executed the attending physician and hed for use as the buriel-tranait	Examiner	Sequentially list conditions.	b	ua to (or as a	consequance of):						
ó	an a		Sequentially list conditions, if any, laading to Immadiata causa. Entar UndarlyIng								į		
68760,	te by	edicai	Cause (Disaasa or Injury that initiated events rasulting In daath) Last	C	ua to (or as a c	onsequance of):						
	tifica as ti	Med	rasoning in daa(ii) Last								1		
Box	andir use			d									
	thet the death cer ed by the attendin detached for use	Physician	Part II. Other significant conditions of	ontributing to death but	not resulting In	tha undarlying	causa c	ivan in Part i	23b. Di	d tobacco use c	ontribute t	o the cau	se of death?
Ö.	P > 3	hys						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Yes 2□No			Unknown
٠ <u>,</u>	be del	ру Р								3,000 20,100	•	,	, and other states
Vital Records,	requires thet sen signed b hould be deta								24a. Wa	s an autopsy	24b. W	ara autop	sy tindings
00	- LI 0	ete							per	formed?	co	mpletion	
Re	The law ate has t page 2 s	Completed										death?	
ā									10	Yas 2 No	1(☐ Yas	2 No
\rightarrow	Physicien: The rthis certificate ral director, pag	Be	25. Was casa ratarrad to medicel axaminar?	Hospital:			10		Death (Check only	ona)			
5	Phys this ral dii	10	1 ☐ Yas 2 No	1 Ki Inpatian			NA		ng Homa 5□ Ra			fy)	
	ing F	on	27. Mannar of Death 1 Natural 5 □ Panding	28a. Data ot Injury (Month, Day		ima ot njury	28c. inj			how Injury occu	rred		
Sic	Attending or death. ector: After by the fune	cat	2 Accident invastigation 3 Suicida 6 Could not b			М	1[Yes 2 No					
Division	l or Attending after death. Director: After I in by the fune	Certification:	3 ☐ Suicida 6 ☐ Could not b 4 ☐ Homicida datarminad	28a. Place of Injur building, atc.	y - At homa, fa (Specify)	rm, straat, facto	ry, office	•		(Straat and Num own, Stata)	ber or Rura	al Routa N	lumber,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.												
	tosp 4 hou fune ely fi	edicai	29a. Cartifiar 1 Cartifying Ph	ysician: To the best of niner: On the basis of a	my knowledga	, daath occurre	d at tha t	tima, data and p	place, and dua to the	a cause(s) and m	nannar as s	itated.	so(s)
	the Figure 2 the Figure 1	8	one)	and manner state	003								
		Σ	29b. Signatura and titla of certifiar	11/	/	2	9c. Licer	nsa number		29d. Data sign	ed (Month,	Day, Yea	7)
	2		and	complated cause of dea	-4	3	D	3676	66	May	5.1	997	>
	nds		30. Name and address of person who	complated cause of dea	ath (item 23a) (Type, Print)							
			Dr. Vik POOR	19% 95	5 Fr	adanie	K	ST. C.	U4 bon,	land,	ud.	215	502
	Sta	ite	31. Date tiled (Month, Day, 1997	Class 32 Majura	alignature	V.				1			
	Registr	ar	MAY 03 1331	0	ma a 68;	¥							

State of Maryland / Department of Health and Mental Hygiene Q 7

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						Cei	rtificate	of	Death		R	eg. No	. 3	1	14004	
П	Dhunia		1. Decedent's Name (First, Middle, Las	t)						2.	Dete of Dee Month _			Vaar	3. Time of Death	
	Physic /Medi		Albert Will:	iam			Gil	Lme	er	A	pril	24	19	97	8:59a.m.	
	Exami		4e. Fecility Name (If not institution, give	street and number)					4b. City, Town	n, or Locat	on of Death	40.	County	of Deeth		
		Щ,	The Memorial	Hospita	1				East			3	Calb	ot		
	Funeral Director		5. Social Security Number 179-09-4549 Usuei Residence of Decedent	7. Age XIM 2□ F 8	9 (In yrs. lest i	birthday) Yrs.	Months D	ear eys	if Under 24 Hours	Min.	Date of Birth (Month, Dev AR • 14	Yeer)	10	9. Birth Cou PEN	place (Stete or Foreign ntry) NSYLVANIA	
	land		10e. Stele 10b. County		10c. City, To	wn or Lo	cation								10d. Inside City Limits	
	the Mary 28a-f sh	Director	MD TAL	вот		I	EASTON					00 00	izen of W		1√2 Yes 2□ No	
	sath with	eral Di	27 BRITTANY TI			140.1		2:	1601			og. On	USA			
Maryland 21215-0020	72 hours after death with the Maryland natural; or items 23a or 28a-f show acal Examiner must be notified at	d by Funeral	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Detes:			Was Deceden If Yes, specify 1□ Yes 2ᡚ			Puerto Rici	an, etc.)			c, White,	can Indian, etc. WHITE	
5-(d within 72 hours plene. r than "natural", the Medical Exe	Completed	15. Decedent's Edit (Specify only highest grad	ucation de completed)	16	Sa. Deced (Give	dent's Usuel C kind of work of DO NOT use r	ccup	ation during most o	of working		16b. K	Ind of Bus	siness/In	dustry	
121		mp	Elementary/Secondary (0-12)	College (1-4or 5-												
2	e filed with al Hygiene. other than	ပိ	12 17. Fether's Name (First, Middle, Last)	5+	A	TTOE	RNEY A	T		Nome (F	irst, Middle, i		AW		M	
an	d be do do do o	Be		OM CITME	D								Sumeme	9)		
2	should be and Mental I marked of urnatic eve	2	WILLIAM ALBEI 19e. informent's Name/Reletionship (T			Ob. Mailie	an Address (C				E STI		. T	Dana W.	0-1-1	
			WILLIAM ALBERT		SON	P.O.	BOX	15		EAVI	TT, M	D 2	2165	2		
Baltimore,	Pe ne		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Burial 2 ☐ Cremetion 5 ☐ Other (Specify,		CHES	APEZ	ration (Neme	EX	MATION	1 4-2	28	OTT	CER	_	own, State MD	
Balti	permit. Departminporta		21. Signature of Funerel Service Licansee 22. Name end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL H 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resolutiony errest Approximate													
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,													
7	/Medical		Immediate Cause (Final disease or condition	Car	diog	en	ie	sl	nock						5 days	
r	Examiner		resulting in death)	8	Due to (or es	e conșeq	quence of):								5 days	
	be iii	ine		ts.	cher	nic	_ h	ea	art	d	(seo	50		- 1	107rs	
o	execut an and riel-tran	Examiner	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Olseese or Injury that initiated events	(Due to (or as	e conseq	uenca of):									
68760,	certificate be executed nding physician and use as the buriel-transit	edicai	resulting in death) Lest													
Box	leath certifice ettending ph d for use as t	2														
	that the death led by the etter deteched for t	Physician/	Pert II. Other significant conditions co	ntributing to death bu	t not resulting	in the ur	nderlying caus	e aiv	en in Pert i.	1	23b. Did tobacco use contribute to the cause of					
0.	by the	Ph.									1 14	/			bably 4 Unknown	
Ś	be det	by	Jep. 10 st	71001												
Division of Vital Records, P.O.	v requir	Completed	Septic sl Preumo Diabet	nia							24a. Was e perfori	n autor ned?	osy	av	ere eutopsy findings ailable prior to empletion of cause death?	
<u>~</u>	The iav	mo	Diabet	es							1 🗆 Y	es 2	INO	1.0	Yes 2010	
a	an: rtifice ctor,	Be	25. Wes case referred to medical						28. Plece of	f Death (C	heck only on	ie)				
2	nysic lis ce	To	examiner?	lospital:	nt 2 ER/C	Dutpatien	t 3 DOA	Oth	or:		5 Reside		8 Other	r (Speci	(y)	
iono	Attending Physician: sr death. ector: After this certific. by the funeral director,		27. Manner of Death 1 ☑ Netural 5 ☐ Pending 2 ☐ Accident Investigation	28e. Dete of Injury (Month, Day	Year) 28b	. Time of injury	28c.		y et k? Yes 2 □ No		Describe ho	ow Injui	y occurre	d		
Divis	or Atter efter des Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of Injurbuilding, etc.	ry - At home, (Specify)	ferm, stre	eet, factory, of	fice		28f.	Location (St City or Town	reet en n, Stete	d Numbe	r or Aura	al Route Number,	
	To the Hospital or Attending Physicien: The is within 24 hours effer death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) 1 Certifying Physical Certifier (Check only one)	sicien: To the best of ner: On the besis of end menner stat	examination a	ge, death and/or inv	occurred et ti restigation, in	ne tin my o	ne, dete end p pinion, deeth	oleca, end occurred e	due to the co	euse(s) ate and	end man I piece, ei	ner as s	nated. the cause(s)	
1	To the vithin comp	Me	29b. Signature and trie of certifier	f m)		29c. Li	cens	e number 9	1	2		te signed		Day, Yeer)	
			30. Neme end address of person who co	ompleted cause of de	ath (Item 23e) (Type, f	Print)									
	100		PETER WHITESELI	L, M.D.	508	IDIF	CALLWE	Αī	ZENUE.	EAS	STON	МГ	21	601		
	Sta		31. Date filed (Month, Dev. Year)	32 Registrer	ds Signature									~ ~ 1.		
	Registr	ar	APR 2 8	1997	7 H.	1.2	Bindate									

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 1997 5:30 p.m. /Medical Mildred Irene Gaver April 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Northampton Manor Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2□F Months Yrs Director 220-18-3223 Feb 20, 1908 Maryland Usuel Residence of Decedent with the Maryland 10b. County 28a-f show 10c. City. Town or Location 10d. Inside City Limits th and Mental Hygiena. ?7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Frederick Myersville 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 409 Main Street 21773 IISA death v Funeral 14. Race - American Indien, Bleck, White, etc. 11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after (Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examine page. 1 ☐ Yes 2 ☐ No If Yes, Give X 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Be Completed by ·3 ☐ Widowed 4 ☐ Divorced Yeer or Detes 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Sales Clerk Department Store 11 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Charles Edgar Baker Rosa Clara 2 Kinna 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Bernard L. Gaver P. O. Box 394, Myersville, Maryland 21773 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Mt.Zion U.Methodist Cemt 4-30-97 Myersville, Maryland
22. Name and Address of Feellity
50% Main Stroot 504 Main Street Ricketts Funeral HomeMyersville, MD 21773 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or healt feilure. List only one cause on each line. Approximete Intervel Between Physician Onset end Deeth /Medical Due to (or es e consequenca of): Coranduna arfen disease Immediete Ceuse (Final diseese or condition resulting in death) **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-trans Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest of Vital Records, P.O. Box 68760, the attending physician Due to (or es e consequença of): Pert II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown δ Completed 24b. Were eutopsy findings evellable prior to 24e. Wes en eutopsy completion of cause of deeth? NA 1 ☐ Yes 2 No 2□ No or Attending Physician: offer death. Director: After this certifica director. 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Certification: To Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation NA 1 Yes 2 No the 2 Accident To the Hospital or Atter within 24 hours efter der To the Funeral Director completely filled in by th 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medicat Exeminer: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner steted. Medical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) TOLL HOUSE AVE FREDERICK MD 21701 31. Dete filed (Month, Day, Year) APR 2 y 1997 32. Registrents Signature State Registrar

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 14536

1 - STATE

	REGISTRAR			ENIIL	CAL	EUF	DEALL		REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last) Beeler GRACE BEALER G					2	2. DATE OF DEATH DAY YEAR APRIL 28, 1997			3. TIME OF DEATH 3:25 A M			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs		st birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		DATE OF BIRTH	6. BIRTHPLA		LACE (State or Foreign	
	220-58-2709)9 1□M2XF 92		YRS.		MONTHS DAYS HOURS		" _I	(Month, Day, Year) Dec. 9, 1	904	004 Maryland		
	9a. FACILITY NAME (If not institution, give street and number)				96. CITY, TOWN OR LOCATION OF DEATH					9c. COUNTY OF DEATH			
5	Fahrney-Keedy Home				Boonsboro					Wa	Washington		
5	RESIDENCE OF DECEDENT										COII		
DIRECTOR	10e. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?			
	Maryland Washington			Hagerstown							t 💢 YES 2 🗌 NO		
A	10e, STREET AND NUMBER				10f. ZIP CODE					10g. CI	TIZEN OF WI	HAT COUNTRY?	
E	1218 Virginia Avenue				2)			U.S.A		
FUNERAL	11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 X			ARMED 13. WAS DE			DECENDENT OF HISPANIC ORIGIN? (Specify specify Cuban, Mexican, Puerto Rican, etc.)			a or No— 14. RACE — American Indian Black, White, atc.		- American Indian,	
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced 1 PORCES 1 YES 2 A IF YES, GIVE WAR OR DATES			1 TYES 2 NO Spe								,	
									White				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working					16b. KIND OF BU	SINESS/IN	IDUSTRY		
E	Elementary/Secondary (0-12) College (1-4 or 5+)			life. Do NOT use retired.)									
MP	0-12			Homemaker			Her own ho						
8	17. FATHER'S NAME (First, Middle, Lest)				100				ME (First, Middle, Maiden Surname)				
BE	Stanley V. Dean				Annabelle Beeler								
6	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Tow									
-	Ernest R. Hoffer/					. 1				n, Md.21740			
	20a_METHOD OF DISPOSITION 1 ABuriel 2 Cremation 3 Rem	AND DATE	ther place	1			DATE 20c. LC						
	A Donellon 5 Other (Specify) Rest Haven Cemetery 5/3/97 Hagerstown, Maryland												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home												
	415 E. Wilson Blvd. Hagerstown, Md. 21740												
	23. PART I. Enter the diseasee, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
	shock, or heart feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Final										Interval Between Onset and Death		
	disease or condition		ACCOUNTS							7 d-n			
1	disease or condition resulting in desth) a. Cutto varanta ttailer DUE TO (OR AS A CONSEQUENCE OF):											- 0)	
_													
CERTIFICATION	Sequentisity list conditions, if eny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
S	ceuse. Enter UNDERLYING												
Ē	CAUSE (Disease Dr Injury thet initiated events DUE TO (OR AS A CONSEQUENCE DF):												
E	resulting in death) LAST	d											
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a, WAS AN AUTOPSY 24b, WE									WERE AUTOPSY FINDINGS			
EDICAL							Part i. 24a. WAS AN AUTOPSY PERFORMED?			AVAILABLE PRIOR TO			
ă	Hosperteenin !						1 _ YES 2 _ NO			OF DEATH?			
Σ	-										1 YES 2 NO		
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE DF DEATH (Check only one)												
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLA	CE DF DEA	QTHE								
YS	1 YES 2 -NO	1 Inpatient 2		3 DOA 28b. T/A	4 Nu	raing Hor		_	Other (Specify)				
H	1 Natural 5 Pending	27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year)				RY WORK?		- 1	28d. DESCRIBE HOW INJURY OCCURED				
ВХ	2 Accident Investigation					M 1 YES 2 NO		-					
	3 Suicide 8 Could not be datermined 28e. PLACE OF INJURY — At building, stc. (Specify)				t home, farm, atreet, factory, office			1	281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)				
COMPLETED													
립	(Check only 1 CERTIFYING PHYS	CIAN: To the best o	t my knowledge, d	leath occur	red at the	time, date	e end place, and	due to	the cause(a) and ma	nner ea si	ated.		
0	One) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(a) and manner as a										end manner se stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NUMBI		BER 29d. DATE S		TE SIGNED	SIGNED (Month, Day, Year)	
) BE	tona mo						D 180		17		April 28, 1992		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
	Vasant Datta 334 Mill Street Hagerstown, Maryland 21740												
	31. DATE FILED (Month, Day, Year) 32/REGISTRAN'S SIGNATURE												
ı	APR 2 9 1997	yala do	A PARTIE	Make,									

and the second second

State of Maryland / Department of Health and Mental Hygiene 9.7

_		_					Cen	iiicat	e of	Death	1		Reg. No.			
			1. Decedent's Name (First, Middle	lle, Last)								2. Date of De			Vac-	3. Time of Death
	Physici /Medi		ROSALIE	KRETZER	GF	ROSS						april	Day 28		997	1100
3	Examir		4e. Facility Name (if not institution	n, give street end nu	umber)					4b. City, To	own, or L	ocation of Deat		County of		
			WASHINGTON CO	OUNTY HOS	PITA	L					HAGI	ERSTOWN		Ţ	WASH	INGTON
	Funeral		5. Sociel Security Number	6. Sex	+	(In yrs. lest birt	hdey)	If Under			24 Hrs.	8. Dete of Bir (Month, De	th			lece (Stete or Foreign try)
	Director		213-24-8668	1□M 20XF		71	rs.	Months	Deys	Hours	Min.	APRIL	9, 19ar)	26	MAI	RYLAND
	2		Usual Residence of Decedent								-					
	n 72 hours efter death with the Maryland "natural", or items 23s or 28s-f show oftes Examine must be notified	_	10a. State 10b. County	1		10c. City, Town	or Loc	ation							1	Od. Inside City Limits
	Me And	Ş	MARYLAND WAS	SHINGTON						BOONS	SBOR	C				1 to Yes 2 □ No
	th th	Director	10e. Street and Number					10f. Zip	Code				10g. Cltiz	en of W	hat Coun	try?
	h wi	a	27 YOUNG AVEN	UE						2171	13				U.S	S.A.
	dea	Funeral	11. Meritel Status	12. Wes Dec		ver in U,S.	13. W	as Deced	lent of I	Hispanic Or	rigin? (Sp	pecify Yes or No Rican, etc.)	- 1			an Indian,
0	or its		1 ☐ Never Married 2 💢 Man		2 X N	0		Yes :				ricall, etc.)			, White,	etc.
21215-0020	Sur Sur	by	3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:		"	10S 4	Z KOL NO	Specify	:			Specify:	V	HITE
5-0	within 72 ho iene. than "natur the Medical	Completed	15. Deceder	nt's Education est grade completed	3	18e.	Decede	ent's Usue	ol Occup	pation during mos	et of work	kina	16b. Kin	d of Bus	siness/inc	lustry
21	5 2	pldu	Elementary/Secondary (0-12)	College		F)	life. D	O NOT us	e retire	d)	St Of WOIR	anig				
		ő	12				CAF	ETER.	IA V	WORKEI	2		COU	NTY	SCHO	OOL BOARD
Pu	be filed ital Hyg d other event,	Be (17. Father's Name (First, Middle,	Last)						18. Moth	er's Nam	ne (First, Middle	, Meiden S	Sumeme)	
la	should be and Mental is marked or umatic eve	10	DAVID FRANKLII	N KRETZER						CAI	RRIE	MAE DE	AN			
Maryland	d 2 should th and Mer 7 Is marks traumatic	ľ	19e. Informent's Name/Relations	ship (Type, Print)		19b.	Mailing	Address	(Street	end Numb	er or Ru	ral Route Numb	er, City or	Town, S	Stete, Zip	Code)
	C T N L		RICHARD W. GRO	SS/SPOUSE		2	7 Y	OUNG	AVE	ENUE,	BOO	NSBORO,	MARY	LANI	2:	1713
ore			20a. Method of Disposition			20b. Piece of cameter	Dispos	ition (Nen	ne of ther ple	ce)		Date	20c. Loc	cation - (City or To	wn, State
E	Peges nent of I nrt: If ite iry or o		1 ☑ Burla1 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S		1 State	MOUNTA					v 5	/01/97	SHAF	PSR	TIRG.	MARYLAND
Baltimore,	permit. P Departme importan any Injur		21. Signature of Funeral Servica	Licensee		_ 11001111	1			ess of Facil						
Ö	permit. Peges Department of Important: If I any Injury or once.		DO OIM	Pa Pa	ul N	1. Dean	BA	ST F	UNE	RAL H	OME	7606 O				
	_		23e. Part 1. Enter the disease of	complications that	caused	the deeth. Do r	ot ente	the mod	e of dvl	no such as	cardiac	Boonsb or respiratory a		Mar	yran	d 21713 Approximete
100	Dhtt	8.4	23e. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	eech lin	ө.	101 071101	the mod	o or ayı	118, 55011 50	0410100	or respiretory a	11001,			Intervei Between Onset end Death
\$	Physician /Medical		Immediate Cause (Finel		D.	0.1	, ,									
	Examiner		disease or condition resulting in death)	a.		reymer		13.5								2 weeks
	3 7	ē			01	Due to (or es e o			1. 1	clas					i	2 weeks ynknim Unknim
	be executed sician end bunal-transit	Examiner		b	-	romic		9	wa	aus	CS					ynknim
Ć,	certificate be executed ding physician end ise es the burial-transit	Exa	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury		- 1	Due to (or es a o	onsequ	ence or):	A -	. 1		h			ĺ	
68760,	sicia bur	cal	Cause (Diseese or Injury that Initiated events	С.		renic	055	MIC	TIW	eu	119	bisco	ine			Unlenson
89	certificate t nding physic	n/Medical	resulting in death) Lest			ue to (or as a c	onsequ	ence or):			7				- 1	
XO		2		d											-	
œ	the death by the atter	Physicia	Part II Other significant condition	ane contribution to	dooth bu	t not requiting in	Alban com a	do de do o o		una la Dani		anh Did	tahasaa :		aulinum an	the same of death 0
P.0	that the death ed by the atter deteched for	hys	Part II. Other significant condition	ons contributing to a	Jeath Du				ause gr	ven in Pert	1.					the cause of death?
	signed to		Cosino	ary As	ren	pr	sea	sc.				10	Yee 2	J No.	3 Prot	ABDIY 4 M UNKNOWN
ds	requires that been signed to hould be dete	d by		0	0							24e. Wes	an autop	sv	24b. We	ere eutopsy findings
00	- L 0	ete										perfe	ormed?		col	alieble prior to impletion of cause
Re	has b	Completed												[death?
Division of Vital Records,	iclen: The L certificate ha		OF Management									10		No	10	Yes 2 No
Zi.		Be c	25. Wes case referred to medica exeminer?	Hospital:	1				Orl	hor		th (Check only				
of	S S D	: To	1 Yes 2 No 27. Menurer of Death	28e. Dete	Inpatier			3 DC	A	4UN	ursing Ho	ome 5 Resi			1-1-1	/)
L C	ding f h. After funer	lon	Naturat 5 ☐ Pendir	ng (Mor	nth, Day		ine or		8c. Inju	rk?	l No.	200. Describe	now injury	OCCUTTE	ea .	
S	Attending or death. ector: After by the fune	Icat	2 Accident investi 3 Suicide 6 Could	not be	= -6.1=i			M		Yes 2	INO	ORI Leastion /	Ctunet one	d Advisor to a	ras Dum	I Doub About a
<u>></u>	or Attendent efter deat Director: Jin by the	Certification:	4 ☐ Homicide determ	nined 288. Plac		ry - At home, fai (Specify)	m, stree	et, factory	, offica			City or To		i Numpe	r or Mura	l Route Number,
ш	urs eral		201 014									-				
	To the Mospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely lilled in by the funeral	edical	(Check only 2 Madicat	ng Physician: To the Examiner: On the E	pesis of o	examination end	death of For inve	occurred a estigation,	at the ti	me, date er opinion, der	nd plece, eth occur	and due to the red at the time,	cause(s)	and mar place, a	nner as st nd due to	ated. the cause(s)
	To the vithin 2 To the comple	Mec	one)'		nner stat	ed.		200	Linna				004 0-44		/1 A 4h	S- V1
	5 ¥ 5 8	-	29b. Signeture and title of certifie	"\n /	-1			-		se number	1					Dey, Year)
			PUV	1	W)			14	449	0		Apr	ll a	0,1	791
			30. Name and address of person		se of de	ath (Item 23a) (* .	rint)	0-	1	2	VSBER	0	Mn	, ,	1711
				ALIK	20	311 LAY	PAT	15	140	12	JUUS	195612	-0	-	4	11)
	Sta		31. Date filed (Month, Dey, Year)	32	Registra	r's Signature										
	Registr	ar	APR 3 0	1991 April	R, Oth	UNITED TO	A.A.									

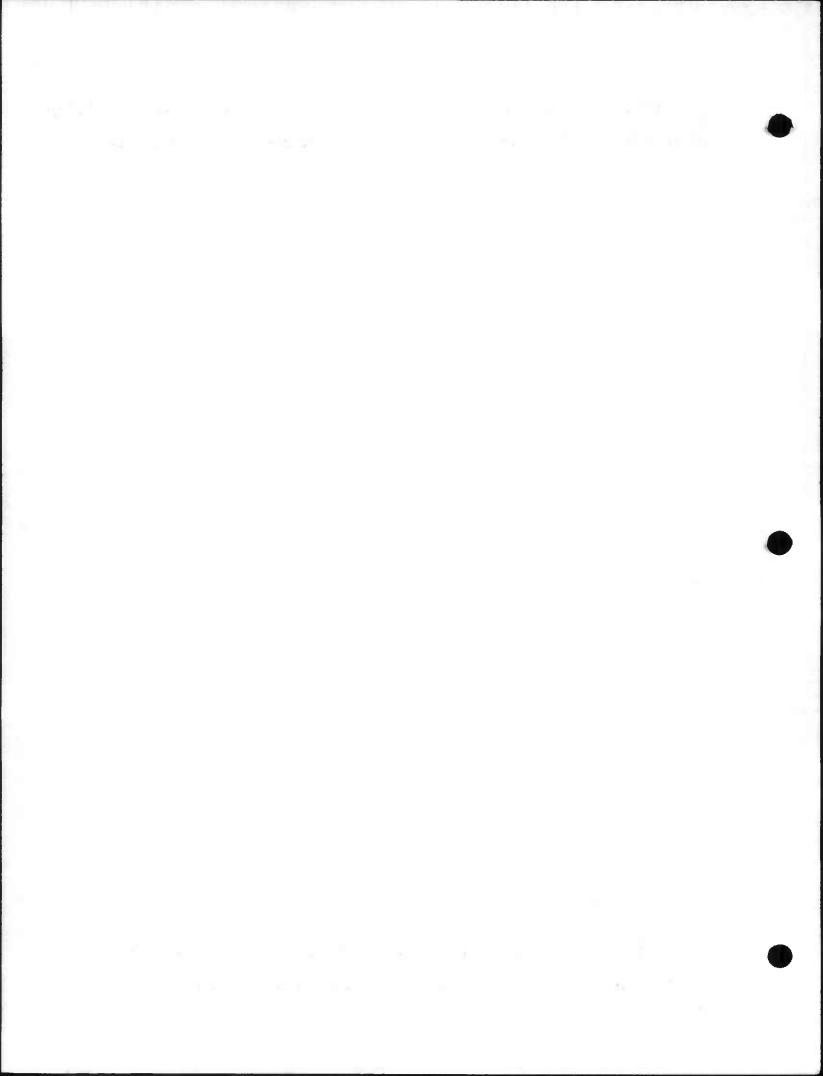


State of Maryland / Department of Health and Mental Hygiene 97 14538

						Certii	ficate	of	Death		1	Reg. No.		
			1. Decedent'a Name (First, Middle, La	ist)							2. Date of Dea	ith		3. Time of Death
×	Physic		VICTOR E	. HUMPHREYS	}						APRIL 1	8. 1	997 Year	0305
1	/Medi Examii		4a. Facility Neme (If not institution, gh	re street and number)					4b. City, To	wn, or L	ocation of Death	1	County of Death	
	LAGIIII	ICI	ATLANTIC GENERA						RERITI	N M	ARYLAND		WORCES'	
	Europal				(In yrs. last birtl	rday) I	f Under 1					h		place (State or Foreign
	Funeral Director			1 □X M 2□ F			fonths D	ays	Hours	Min.	8. Date of Birt (Month, Day MAY 20		Cou	XANDRIA, VA
	dand		10a. State 10b. County	1	I0c. City, Town	or Locati	ion							10d. inside City Limits
	the Mery 28a-f sh	Director	MD WORCEST	ER	OCEAN									1 ☐ Yes 2 X No
	J within 72 hours after death with the Meryland jiene. I than "natural", or items 23s or 28s-f show the Modes! Exercise must be inclined.	rai Dir	12635 OLD BRIDG	E ROAD			10f. Zip Co 218		2			10g. Crtize	en of What Cou USA	intry?
	e L	Funeral	11. Meritel Stetus	12. Was Decedent Ev Armed Forces?	er in U,S.	13. Was	s Deceden	t of I	Hispanic Ori	igin? (Sp	ecify Yes or No- Rican, etc.)	14	I. Race - Amer Bieck, White	
020	ours afte	by	1 Never Married 2 Merried 3 Widowed 4 Divorced	1 XYes 2 No If Yes, Give Year or Detes: U			Yes 2X					s	Connectify:	HITE
21215-0020	in 72 ho n "natur	Completed	15. Decedent's E (Specify only highest gri	ade completed)		Give kind	t's Usual C d of work o NOT use i	fon e	during mos	t of work	ring	18b. Kind	d of Business/li	ndustry
212	iene.	E	Elementary/Secondery (0-12) 7th	Coilege (1-4or 5+)		FTSHI	ERMAN		·			CON	MERCIA	r.
	등 독립 부	BeC	17. Fether's Neme (First, Middle, Last)	-	LUII	ord III I		18. Mothe	er's Nam	e (First, Middle,			
a	0 2 0 0	To B	LOUIE W. HUMPHRE	YS					IS	ABEL	PAINTE	R		
Maryland	0 6 6 5	_	19a. fnformant's Name/Relationable (_					al Route Numbe	-		ip Code) ND 21842
	of Health item 27 i		20a. Method of Disposition	KLIU	20b. Plece of				DOL K	<i>D</i> .,	Date		ation - City or T	
Baltimore,	Pages nent of I ant: If ite		1 X Burlei 2 ☐ Cremation 3 ☐		cemetery	, cremate	ory or othe	r pie		122				
뜶	it. P.		4 □ Donation 5 □ Other (Special Structure of Funeral Service Ligation 1)		SUNSET								LIN, MA	ICES, LTD.
Ba	permit. Pages Department of Important: If it any injury or o		1 Stoke	Melle					ess of Facilit	F	RANKFOR	D, D		
			23a. Part1. Epter the disease of form shock, or heart fallure. I is only	plications that caused th	e death. Do no	ot enter ti	he mode o	f dyl	ng, such as	cardiec	or respiratory ar	rest,		Approximate Interval Between
	Physician		V	5110 02000 011 00011 jirlo.							_			Onset and Deeth
7	/Medical		Immediate Cause (Final disease or condition		Com	مسا	/	5	nta	^	Dixe	20		
8	Examiner		resulting in death)	e. Di	ue to (or as a co		Y			1				
-	D #	Examiner	1_		Chris	iest	Lie.	1	Jeant	7	Fa. Zu	0		
	acute and trans	cam	Sequentially list conditions, if any, leading to immediate	D.	e to (or as a of	7	nce of):							
Ő,	Sian a		cause. Enter Underlying Cause (Disease or injury		Care	Line	2_	1	Au		Hun. o	-		
68760,	the the	edical	that initiated events resulting in death) Lest	Du Du	e to (or as a co	nsequen	ice of):			0				
×	eath certificate be executed ettending physician and I for use as the burial-transit	≥		d										
P.O. Bo	requires that the death cer ween signed by the ettendin hould be deteched for use	Physician	Part II Other elemitions conditions	antillitation to doubt but	and the state of t		4.4	e i 20	- 1- D. A.		ook place	. X	i	
O.	the cy the	hys	Part ii. Other significant conditions of	ontributing to death but i	not resulting in	tne unde	rrying caus	ie gr	ven in Pari					to the cause of death?
О.	that bed to det	by P									101	20	No 3□Pro	obably 4 Unknown
Records,	- w D	q P									24a. Was	an autops		Vere autopsy findings
000	v requir	Completed									perfor		a a	valleble prior to ompletion of cause
Re	sician: The law certificate has b lirector, page 2 s	ם										_ \		death?
_	icate icate v, pa		05 144								1 U Y	es 200	No 1	☐ Yes 2☐ No
Division of Vital	centif	Be C	25. Wes case referred to medical examiner?	Hospital:				Ott	har		h (Check only o			
0	Phys this rai di	. To	1 ☐ Yes 2 ②No 27. Manner of Death	1 ☐ Inpatient 28e. Date of Injury	2 DEFVOutp		3 DOA		4 - 140		me 5 Resid			ify)
ב	After fune	ion	1 Natural 5 ☐ Pending	(Month, Day Y		ury	28c.		rk? Yes 2 □		28d. Describe h	ow injury	occurred	
2	death death stor:	cal	2 Accident investigation 3 Suicide 6 Could not b	9	Ashama fam				Tes Z	NO	Opt Leasting /	Manad and	March and an Chin	- Courte Manager
<u>></u>	or A after Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Injury building, etc. (Specify)	n, street,	ractory, or	TICE			City or Tow	n, State)	Number or Hul	ral Route Number,
	pital ours oral filled		29a. Certifier 1 Certifying Ph	velolen. To the best of a	nu lenguda da d	donth				4 - 1				
	To the Hospital or Attending Physician: To thin 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edicai	(Check only one)	ysician: To the best of n niner: On the besis of ex and manner state	camination end/	or Invest	igation, in	my c	ppinion, deal	d place, th occurr	ed at the time, o	ause(s) a late and p	no manner as : lace, and due t	to the cause(s)
	Nithin Fo th	Me	29b. Signeture end title of certifier				29c. Li	cens	se number			29d. Dete	signed (Month,	Day, Year)
	> - 0	1	1 Stephen	Water	· W	0	7	,2	799	3		4	12219	17
		p	30. Name and address of person who	completed cause of deal	th (item 23a) (T	vne Prin					n +		1 1	
			1001 74	il. Delyd	in	Su	ence	_		عصر	on Cit	7	and	
	Sta Registr		31. Date filed (Month, Day, Year) APR 2 3 1997	32. Registrar's	Signature	2						0		
			111 11 40 .00.	//										

State of Maryland / Department of Health and Mental Hygiene 9 7

						Cen	tificate of	Death		Reg. I	No.			
			1. Decedent'e Name (First, Middle, La	est)					2. Dete	f Deeth			3. Time of Dea	ith
	Physici /Medi		Milton Eugene	Harley					Apri		,1997	Year 7	9:45p.1	m
	Examir		4e. Facility Name (If not institution, gir					4b. City, To	wn, or Location of E		4c. County		J. 45p.1	
	Exami		14105 Beverly	Drive				Hugh	esville		Char!			
	Funeral				yrs. last birt	hday)	If Undar 1 Yaar	If Undar					aca (State or Fo	reion
	Director		220-28-5603	10xm 2□ F 6		Yrs.	Months Deys	Hours	Min. (Month	f Birth , Day, Yee Ty 14	1930		aca (Stata or Foi ry) rland	Olgit
	Bud *		Usuel Residence of Decedent 10e. Stete 10b. County	100	c. City, Town	or Loc	ation					1/	d. Inside City Lir	mite
	sho sho	ō			Waldo							10	1 XYes 2	
	the A	Director	Maryland Charles 10e. Street end Number		Waluc)T.T.	401 71 0 4							
	23a or	al Dir	4815 Bryantown Ro	ad			10f. Zip Code 20601				Citizen of W ISA	/het Count	ry?	
	9	Funeral	11. Marital Status	12. Wes Decedant Ever Armed Forces?	in U,S.	13. W	as Decedent of H	lispenic Ori	gin? (Specify Yes o	r No-		- Amarica k, Whita, a		
21215-0020	4 within 72 hours after death with the Meryland jiene. r than "naturel", or itema 23a or 28a-f show the Medical Examinet must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:			□Yes 2□No	Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,			ican India	an
50	72 ho	Completed	15. Decedent's E		16e.	Deceda	int's Usual Occup	ation		16b.	Kind of Bu	siness/ind	ustry	
21	- 2	ple	(Specify only highest grant Elementary/Secondery (0-12)	Coilege (1-4or 5+)		life. D	ind of work done O NOT use retired	dunng mosi d)	t or working					
21	filed within Hygiene. offer than	ГО.	12		T	ruck	Driver			Nat	ional	Parl	k Servic	e
pu	e filed el Hygie other vent, p	Be (17. Fether's Neme (First, Middle, Last)				18. Mothe	er's Neme (First, Mi	ddle, Maid	en Sumamo	a)		
/la	should be and Mentel americal urmatic eve	To	James Bernard Ha	rley				Marth	na Savoy					
Maryland	2 sho end h is me		19e. Informent's Name/Relationship (Type, Print)	19b.	Meiling	Address (Street	and Numbe	er or Rural Route N	ımber, Cit	y or Town,	State, Zip	Code)	
			James Carroll Ha	rley So	n 150	048	Woodvil	le Roa	ad, Waldo	rf, M	aryla	nd 20	0601	
ore	is 1 and of Health Item 27 other tr		20e. Method of Disposition	20	Ob. Plece of	Disposi	ition (Name of atory or other place	ne)	Dete	20c.	Location - 0	City or Tov	vn, State	
E	Peges nent of I ant: If Ite		1 Buriel 2 □ Crametion 3 □ Donetion 5 □ Other (Special	JRamoval from Stete			s Cathol	-	April 29,	Wal	dorf,	Mars	rland	
Baltimore,	교원관들		21. Signature of Funaral Sarvice Lice				Name end Addra		199/	1102.1.	doll,	11012	1010	
ä —	Depa impo any i		Iloya M	1. Catel	>	Adar	ns Funeral	. Home 2	20605 Aquas	co Roa	d, Aqu	asco,	20608 Maryland	
я			23a. Pert1. Enter the difease, or com shock, or heart future. List only	plicetions thet caused the one cause on each line.	deeth. Do n	ot enter	the mode of dyir	ng, such as	cardiec or respireto	ry errest,			Approximate Intervel Between	
	Physician		8									į	Onset and Death	1
6	/Medical Examiner		Immediate Cause (Final disease or condition	Pancrea	atic	Can	cer					i	177	
	Examinio.		resulting in deeth)	Due	to (or es e c	onsequ	ence of):							
	be is	ine		b								1		
	tificate be executed g physician end es the burial-transit	Examiner	Sequentially list conditions,	Due	to (or es a c	onsequ	ence of):							
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68760,	hysic the t	d C	thet Initieted events rasulting in deeth) Last	Due	to (or as a co	onseque	ence of):							
9 x	ertificate be executed ling physician end se es the bunal-transit	Medical		d										
Bo	0 2 9			U								1		
o.	that the death ed by the atter detached for i	Physician	Pert II. Other significant conditions of	ontributing to deeth but not	resulting in	the und	derlying cause giv	en in Perti	. 23b.	Did tobac	co use con	tribute to	the cause of de	ath?
<u>α</u>	ed by detac									Yee	2□ No	3 Prob	nbly 4 Unkr	nown
S,	8 5 8	by	H											
Record	v require been si should	Completed								Ves en eu erformed?		ava	re autopsy findin llebie prior to	
ec	Ne ls L	npie										of d	pletion of cause eath?	
	The ate h	50								☐ Yes	24 No	1 🗆	Yes 2 No	
<u>ta</u>	Physicien: The rthis certificate and director, peg	Be	25. Wes case referred to medical examinar?					26. Place	of Deeth (Check o	nly one)				
2	Physic this ce al dire	2	1□ Yes 2□ No	Hospitel: 1 Inpatient	2 ER/Out	petient	3□ DOA Oth	er: 4 🗆 Nu	rsing Home 54	Sesidence	6 □Othe	r (Specify)	
0	ding Pi h. After th funera		27. Manner of Death ↓□ Neturel 5 □ Pending	28e. Dete of Injury (Month, Day Yea	28b. Ti	ime of	28c. Injur Wor	y et k?	28d. Dasci	ibe how in	jury occurre	ed		
0	Attending or death. ector: Afte by the fune	atic	2 Accident Investigation	n		,,,		Yes 2 1	No					
Division of Vital	or Attendate deat after deat Director:	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Piece of Injury - A building, atc. (Sp	At home, fer	m, stree	et, fectory, offica			on (Street Town, Sta		or Or Rural	Routa Number,	
	s after of in by	Ce		bullottig, ato. (Op	racity				only of	70111, 012				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29e. Certifier (Check only one) Certifying Ph	ysician: To the best of my niner: On the basis of axan	knowledge, ninetion end	death o	occurred at the tin stigetion, in my o	ne, dete en pinion, dee	d place, end due to th occurred at tha ti	the ceuse me, dete e	(s) and mer and pleca, a	nner es ste	eted. the cause(s)	
	within 2 To the comple	Me	29b. Signature end title of certifier	and menner steted.			29c. Licans	a number		29d F	Dete signed	(Month F	av. Yearl	
	F ≯ F ŏ		Wai 10	M M	20									
		-	- Round	16. 16	00/~	^	D2835	2		Apr	ril 2	8, 1	997	
			30. Name and address of person who					_		_	0.5			
	-01		Krishan Mathur 31. Date filed (Month, Day, Year)	M.D P	ignature	ROX	2129,	La Р	ıata, M	ע	2064	6		
	Sta Registra			32. Registrer's S	welson	Rand	all.							



State of Maryland / Department of Health and Mental Hygiene

14540

						Cer	tificate of	Death		R	eg. No.		. 0 . 0
	Physic /Medi		1. Decedant's Nama (First, Middla, Las Mary	Kather:	ine Ha	ywa	rd			Data of Dee Month 1	th 25 ^{Day} 199	Voor	Time of Death 2 PM
	Exami		4e. Facility Nama (If not institution, give Solomons Nurs		er		S	4b. City, Too Solom	wn, or Locati	on of Deeth	4c. County Cal	of Deeth vert	
	Funeral Director		5. Social Security Number 6. S 538 40 7167 Usuai Rasidance of Decedant	ax 7. Aga 7. Aga 8.4	a (In yrs. last b	Yrs.	If Under 1 Year Months Days	if Under: Hours	24 Hrs. 8. Min. Au	Data of Birth (Month, Day 199	Year) 1912	9. Birthplaca Country) Color	(State or Foreign
	Maryland Ff show	tor	10a. Stata 10b. County Maryland Calver	t	10c. City, Too Solo								nsida City Limits □ Yas 27 No
	ath with the 23s or 28	ral Direc	10e. Street end Number 13325 Dowell F	Road			10f. Zip Coda 20 6	588		1		What Country?	es
000	72 hours efter death with the Maryland "natural", or flems 23s or 28s-f show oldel Examiner must be notified at	by Funeral Director	11. Maritel Stetus 1 ☐ Naver Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dacedent II Armed Forces? 1 ☐ Yas 2 ☑ N If Yes, Giva Yaar or Datas:	Ever in U,S. No		Vas Decedant of I Yas, specify Cub		gin? (Specify n, Puerto Rica	Yas or No- an, etc.)		ce - American Inck, White, etc. www.www.ite	· neit
21215-0020	C 2 6	Be Completed	15. Decedant's Ed (Specify only highast gra Elamantary/Secondary (0-12) 1 2	ucation de completed) Collega (1-4or 5		(Give	ent's Usual Occu kind of work done DO NOT usa retire	during most d)	t of working			home	
pu	al Hygid other verit, ii	3e C	17. Fathar's Nama (First, Middla, Last)					18. Motha	r's Nama (Fi	rst, Middla, I	Maidan Suman	na)	
yla	should be and Mental I	2	August Ainswor	th Harri	İs			Sad	ie Ma	e Gre	een		
Baltimore, Maryland	C1 c0 m m		19a. Informant's Name/Raiationship (7 Lynda Lacy- Ada	, , , , , ,			g Addrass (Street Box 18						
			20a. Method of Disposition 1 Burlal 2 Cremetion 3 4 Donation 5 Other (Specify	Ramoval from Stata	20h Place	of Disnor	sition (Name of natory or other plane) Memoria		-	and T	20c. Location	City or Town, S	Stete
Balti	permit. Pege Department of Important: If any Injury or once.		21. Signeture of Funaral Sarvice Licen	see		22	. Neme end Addra	ass of Facility	Raus	ch F		Home	
	Physician		23a. Part1. Entar tha disease, or companock, or heart failure. List only	dications that caused one cause on each lin	tha daath. Do		05 Broomer tha moda of dyl					App	roximata 20 (val Batween 0 (et and Death
1	/Medical Examiner		Immediata Causa (Final diseesa or condition rasulting in daath)	end s	tage Dua to (or as a	A/	2heimer	3	Disea	se		C	know
-	gi gg	liner		h	0 (0) 40 6	0011004	duriou ory.						
o,	an and	Examiner	Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaasa or Injury that initiated evants	1	Dua to (or as a	consaq	uance of):						
ox 68760,	certificate be executed nding physician and use as the burial-transit	n/Medical	Cause (Disease or Injury that initiated events rasulting in death) Last	d	Dua to (or as a	consequ	uence of):						
Ď.	death	icia	Part ii. Other significant conditions co	ntributing to death bu	ıt not resulting	In the un	darlying causa di	ven in Part I		23b. Did to	phacco use co	ntribute to the	cause of death'
, P.O	requires that the death seen signed by the ette hould be detached for	by Physician		/ /		,	passing	13			es 2 No		31
of Vital Records,	aw requires been s	Completed t	Lurine cotpi	t noted						24a. Was a perform	n autopsy med?	avallable	utopsy findings a prior to lon of cause ?
E H	E ag	Con								1 □ Y	as 2XNo	1 ☐ Yas	2□ No
VIII.	Physician: The this certificate ral director, pag	e B	25. Was casa refarred to medical axaminar?	Hospitel:			0		of Death (C				
to	5 00	- To	1 Yas No	1 ☐ Inpatia		utpatient	3LI DOA	NU			ance 8 Oth		
Division	Attending I or death. ector: After by the fune	cation	Denoting 5 ☐ Panding invastigation	(Month, Day		Injury	M 1□	rk? Yas 2□!		Dascrice III	SW IIIJUIY GCCGI	100	
Divi	al or Attendis s efter death. Il Director: A ed in by the fu	Certification:	3 ☐ Sulcida 6 ☐ Could not be 4 ☐ Homicida datarmined	28a. Placa of inju building, atc		arm, stra	at, factory, offica		28f.	Location (SI City or Town		per or Rural Rou	ta Number,
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: Affer thi completely filled in by the funeral	edicai	29a. Cartifiar	sician: To the best of lnar: On the basis of and mannar sta	axamination at	a, daath nd/or inv	occurred at tha ti astigation, in my	ma, data and opinion, daat	d place, and th occurred a	dua to tha co t tha tima, d	ausa(s) and ma ate and place,	annar as stated. and dua to the o	ausa(s)
	,	X	29b. Signature and title of certifier	Mard	10 4	0		476/	10	2	9d. Data signa $4/2$	d (Month, Day,	Year)
	6		30. Nama and addrass of person wife of David J. Tard				Print)	Rd P	rince	Fre	deric	/ MD 2	0678

State Registrar

State of Maryland / Department of Health and Mental Hygiene 9 7

						Ce	rtificate	e ot	Death			Reg. No.		
	Physic /Medi		1. Decedant's Nama (First, Middle, James S	herman	Hav	wkins					2. Data of De Month April	Day 24	1997	3. Time of Death 3:25 A.M.
	Exami		4a. Facility Neme (If not institution, g 7495 Solomons						Sun	der1	ocation of Deat and		nty of Death Calve	
	Funeral Director		213-22-0224	Sex 1XXM 2□ F	7. Age (In yrs	s. last birthdey; B Yrs.	If Under Months	1 Yaar Days		24 Hrs. Min.	8. Dete of Bi (Month, Di June I	tth ay, Year) 1928	9. Birth	npiece (State or Foreign intry) aryland
	e Maryland Ra-f show	ctor	Usuel Residence of Decedent 10a. State 10b. County Maryland Ca.	lvert	10c. C	City, Town or L	Sunde	rla	nd					10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	or 28	Oire.	10e. Street and Number				10f. Zip	Code				10g. Citizen	of Whet Cou	untry?
	ath w	rai	7495 Solomons	Island	Road			068					SA	
020	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or hems 23s or 28s-1 show but, the Medical Examinet must be notified at	by Funeral Director	11. Meritel Status 1 Navar Married XX Married 3 Widowed 4 Divorced	Armed Fo	2X No iva	1	Wes Deced If Yes, spec			gin? (Sp i, Puarto	pecify Yes or No Rican, etc.)		Race - Amer Black, Whita city: B1	
5-0	natur	ted	15. Decedent's (Specify only highest)	Education		16a. Dece	dant's Usua	l Occup	pation	t of work	rina	16b. Kind o	Businass/I	ndustry
21215-0020	filed within Hyglene. ther than "	Completed	Elamantary/Secondery (0-12)		1-4or 5+)		ok Dr		during mos ad) T			Exc	avatio	on
Maryland	Mental Mental arked o	To Be	17. Fether's Neme (First, Middle, La William Wi	s() Lfred	Hawk	ins				er's Nem zett	e (First, Middle a		tep	
_	2 she and la ma		19a. Informent's Neme/Relationship			19b. Maili	ng Address	(Street	t and Numbe	er or Rur	re/ Route Numb	er, City or To	wn, State, Z	ip Code)
_	Health Health am 27		Elizabeth Hawkin	ns/Wife	001	P.O.	Box		Sur	nder	land, M			
Baltimore,	80= 5		20a. Method of Disposition 1 Burlel 2 □ Cremetion 3 4 □ Donetion 5 □ Othar (Spe		Stata	cematery, cre	matory or of	her ple	,	7 4	/28/97	20c. Location	ian, l	
Bal	permit. Pa Departmen Important: any injury		21. Signeture of Funerel Service Lic	۸	0 0	2:	2. Nema and	d Addre	ass of Facili	y Ser	well Fu	neral	Home	
_	70 F 4 0		Dladys a.										erick	, MD 20678
	Physician /Medical Examiner		23e. Part 1. Entar the disease, or co shock, or heart feilure. List on Immediate Cause (Finel diseasa or condition resulting in death)										/	Approximate Interval Between Onset and Death
-	D #	inei			59	uar	nou	1	cel	L	01	mes	ast	esis-
68760,	certificate be executed iding physician and ise as the bunal-transit	/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Lest	c	Due to	or es e conse	quence of):							
Box				d										
P.0.	that the death ned by the atter detached for u	Physician	Part II. Other eignificant conditions Alexander Part II. Other eignificant conditions	contributing to d	eath but not re	suiting in the u	enderlying ca	use gi	ven in Pert I	e		tobacco use Yes 2□ N		to the cause of death?
Division of Vital Records,	requires been sign should be	Completed by	Otheros o Chrand Emp	2 06	st.	Port	m.	9	0/5-	ē	24e. Wes	en eutopsy ormed?	a	Vere eutopsy findings vailable prior to ompletion of causa of death?
Re	he law a has	mo mo	Emp	Lyst	ma						10	Yes 200		□Yes 2□No
ita	ysician: The l is certificata he director, page	Be C	25. Was case referred to medical	T					26. Plece	of Deat	th (Check only,			2.00
f V	ysici is cer direc	To	examiner?	Hospitel: 1	Inpatient 2	☐ ER/Outpatie	nt 3 DO	A Oti	her:	ırsing Ho	1./	idence 6 🗆	Other (Spec	ify)
ion o	nding Ph ath. r: After th		27. Menper of Deeth Netural 5 Pending 2 Accident investiget		of Injury th, Day Year)	28b. Time of Injury	f 28	Bc. inju Wo	ryat rk?]Yes 2 □	No	28d. Describe	how injury oc	curred	
Divis	al or Atte s after de i Directo d in by th	Certification:	3 Suicida 6 Could not determine	d 289. Place	e of Injury - At I ing, etc. <i>(Spec</i>	home, ferm, st	reet, fectory	, office	9			(Street end No wn, Stete)	mber or Ru	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completaly filled in by the funeral director,	edical (29a. Certifying E (Check only one) 2 Medical Ex-	Physician: To the aminer: On the beand men	best of my kn asis of examin ner steted.	owledge, deet etion and/or in	h occurred e vestigetion,	in my	me, dete en opinion, dee	d place, th occur	and dua to the red at the time,	ceuse(s) and dete end plea	manner as e, and due	stated. to the causa(s)
	To the To the Comp	M	29b. Signature and title of certifier	1	1		1		sa number			29d. Dete sig		
	П		M.P.	She	de			0 -	22	63	4	4-2	5-7	5
	[30. Neme and address of person when Mahesh Shall	n, M.D.						Pri	nce Fre	derick	, MD	
	Sta Registr	ite ar	31. Date filed (Month, Day Year)	5 1997	Jalia 6	Saucton-	Rordall	8, 11						

State of Maryland / Department of Health and Mental Hygiene 97 14542

					Cert	ificate of	Death		Reg. No.	J 1	14046
Physic	cian	Decedent's Name (First, Middle VIRG		TiTN				2. Date of D Month		Year	3. Time of Deeth
/Med	lical					H	FORNE, SR	· APRIL	14,199	1)	2211
Exam	iner	4a. Fecility Name (If not institution	Transcription of the second		משח		4b. City, Town, or	Location of Dee		ty of Death	
Funera Director		PENINSULA REG 5. Social Security Number 221–26–0495		ge (in yrs. lasi	t birthday)	If Under 1 Year Months Days	if Under 24 Hrs			9. Birth	nplace (State or Foreign WARE
JII 60101		Usual Residence of Decedent						1.00.	, , , , , ,		
a-f show	ctor	10a. State 10b. County DELAWARE SUSSE	X		own or Loca FORD	tion					10d. tnside City Limits 1 ☐ Yes 2 No
23a or 28	Funeral Director	10e. Street and Number RT 1 BOX 309F				10f. Zip Code 19973	3		10g. Citizen of AMERI		intry?
r heath and Mental Flyglens. The marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Extriner must be notified at	by	11. Marital Status 1 Never Married 2 Merri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Tyes 2 1 If Yes, Give Year or Dates:	? No		ns Decedent of I es, specify Cub	Hispanic Origin? (S ean, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)		aca - Ameri ack, White ify: WHI	
natu	eted	15. Decedent (Specify only highes	's Education t grade completed)	1	6a. Deceder (Give kir	nt's Usual Occup nd of work done	pation during most of wo	rking	16b. Kind of I	Business/ir	ndustry
than	Completed	Elementary/Secondary (0-12)	College (1-4or			NOT use <i>ratire</i> UTTER	od)		RETAIL	SALE	S
c event,	Be	17. Fether's Name (First, Middle, IFRED LE					18. Mother's Nar PEGGY F				
27 is marked or r traumatic eve	T _O	19a. Informant's Name/Relations! JEAN A. HORNE	nip (Type, Print) WIFE	1	19b. Mailing RT 1 I	Address (Street	t and Number or Ru SEAFORD	ural Route Numb	per, City or Town ARE 199	n, State, Zij 73	p Code)
int; if them 27 iry or other tr		20a. Method of Disposition 1 Derial 2 Cremation 4 Donation 5 Sher (Sp	3 □Removal from State	ceme	etery, crema	ion (Name of tory or other pla IETERY	ce) 4	Date /18/97	20c. Location OAK GR		own, Stete DELAWARE
Important: If it any injury or a once.		21. Signature of Fundal Service I	11) (TII			YATES TUN		•		
sician		23 Part See e disea 6 or shoot, or heart failure List of	complications that cause only one cause on each i	d the death. D	Do not enter	the mode of dyle	ng, such as cardia	or respiratory a	arrest,		Approximate Interval Between Onset and Death
edical miner	ı	Immediate Cause (Fin II disease or condition resulting in death)	a. EN			OPATI	7 4				7 DAYS
	ě		An	Due to (or as		ince of):					7 DAY
physician and s the burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury	0.	Due to (or as	a conseque		_				7 DAYS
iysicia he bur	edical	Ceuse. Cliseese or injury that initiated events resulting in death) Last	c	Due to (or as	e conseque	AAR,	ESF				+ 01713
5 6	2	resulting in death) Last	d. A	•		· ·	BIUA	MI			7 AAY
he att	Physician	Part II. Other significant condition	ns contributing to death b	out not resulting	g in the unde	ertying cause giv	ven in Part I.	23b. Did	tobacco use co	ontribute t	to the causs of death?
igned by the attend be detached for us	by Phy							10	Yes 2□ No	3 Pro	obably 4 Unknown
s peen s	Completed b							24a. Was	an autopsy ormed?	av	Vere autopsy findings vailable prior to pmpletion of cause i death?
nis certificate has								1 🗆	Yes 2□No	11	☐ Yes 2☐ No
ector.	Be	25. Was case referred to medical exeminer?	Hospital:				26. Piace of Dea				
= 0	<u>۲</u>	1 Yes 2 No 27. Manner of Death	28e. Dete of inju		Outpatient b. Time of		4 Li Nursing H	ome 5 Resi	denca 8 DOt		fy)
ctor: After y the funer	cation	1 Natural 5 ☐ Pending investign	(Month, Da	y Year)	Injury	M 1□	rk? Yes 2□No	200. Describe	riow injury occu	1160	
or d	Certification:	3 Suicide 6 Could n 4 Homicide determine	ned 286. Piece of in	jury - At home, c. (Specify)	, ferm, street	, factory, office		28f. Location (City or To		ber or Run	al Route Number,
To the Funeral C completaly filled	edicai	29a. Certifier (Check only one) 1 CertifyIng 2 Medical E	Physician: To the best xaminer: On the basis o and manner st	f examination	dge, death oc and/or inves	ccurred at the tir tigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	ceuse(s) and m date and placa,	anner as s , and due to	itated. o the cause(s)
Tot	Σ	29b. Signeture end title of cartifier	. /	1 -		29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
		DA F G	hordnich	ı		0	20912		4-1	15-1	9-2
		30. Name and address of person w	the completed cause of a	death (Item 23)		INDY .	2-09/2 31. SAU	shird n	nn 218	01	
Sta		31. Dete filed (Mo PR. 108)		AS SHEETHING	Parlall		JAN.	1			The second of th
Registi	rar										

				State of M	viaryland /		rtment of F		id Mental i	Hygien Reg. N	(97	145	143
	Physic /Medi		Decedenl's Nama (First, Middle, La	ss() Shirl	ey E.		HENRY		2. Date of Month	D	ay 199	Year	3. Time of 001	
9	Exami		4a. Facility Nama (If not institution, gi		· ·				, or Location of D		c. County			
┞		-	PENINSULA REGION 5. Social Security Number 6.		L CENTE. Age (In yrs. lest)		If Undar 1 Year	SAL1	SBURY	Dieth			(04.	
	Funeral Director			1□ M 2⊠ F	61	Yrs.	Months Days		Min. (Month	Birth Dey, Year 2, 19			aca (State o 'ry) aware	or Foreign
	yland		10a. State 10b. County		10c. City, To	own or Loc	cation					10	d. Inside Ci	ity Limits
	the Marylar 28a-f show	ctor	Delaware Sussex		Laur	e1							1 ☐ Yes	2₺ No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10g. C	itizen of V	Vhal Count	ry?	
	a 23a	rai	Rt.# 3 Box 201				1995				S.A.			
020	be filed within 72 hours efter death with the Maryland tall Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decader Armed Force: 1 Yes 28 if Yes, Give Year or Datas	s? I No	If	Vas Decedant of H Yes, specify Cuba	an, Maxican, P	? (Specify Yas or ruarto Rican, etc.)	No-		e - Americe k, Whita, e		
Baltimore, Maryland 21215-0020	n 72 hours "natural",	ted	15. Dacedent's E	ducetion		a. Deced	ant's Usual Occup	ation		16b. I	Kind of Bu	siness/Ind		
21	within 7 ene. than "n	Completed	(Specify only highest grant (0-12)	ade completed) Collaga (1-4o	r 5+)	(Giva I lifa. D	kind of work done of NOT use retired	during most of d)	working					
12	filed within Hygiene. other than ent, the Me		8 17. Father's Name (First, Middle, Last	1		Sea	amstress	40.14.11.1				nt Con	npany	
and	should be filed and Mental Hygin marked other imatic event,	Be c	Layton E. Timmon						Neme (First, Mid			(e)		
aryl	es 1 and 2 should be f of Heelth end Mental I f Itam 27 is marked of if other traumatic eve	70	19a. Informant's Name/Relationship (1	9b. Mailin	g Address (Streat		Sirman '			State Zin	Code)	
Š	elth e		Harold R. Henry/			Rt.#			Laure				2000)	
ore	of He litem		20e. Method of Disposition 1 XBurial 2 Cremation 3 C	In	20b. Place	of Dispos	sition (Nema of setory or other pled		Data	-		City or Tov	vn, State	
im	Pages ment of I ant: If its ury or of		4 Donation 5 Other (Specif		е		le Cemete		4-26-9	7 Be	thel.	Dela	aware	
3alt	permit. Pages Depertment of H Important: If its eny injury or of		21. Signature of Funeral Service Licer	nsaa	0. ,		Nama and Addres	-						
	00 = 0 a		Milliam 1	Sho	11	7 (nort Fund 00 West S	Street	Laure	1. DE	199	956		
			23a. Part1. Enter the disaase, or com shock, or heart failura. List only	plications that cause ona cause on each	cleath. D	o not ente	r tha mode of dyln	g, such as car	diac or respiretor	y arrest,			Approximate Interval Bate Onset and D	e ween
	Physician / /Medical		Immediate Cause (Final	ACITO	DD WT 111	.mii 0	ADDIOGRA	TO 01100	217			1		
	Examiner		disease or condition resulting in death)	a. ACUI	1000 1000		ARDIOGEN	IC SHOC	JK				5 day	ys
_	p ==	ner		DTAI	Due to (or as								5 day	ys
	and -trans	Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	b. DIAI	Dua to (or as		2							
68760,	icete be executed physicien end s the buriel-transit		Cause (Disease or injury	C										
587	phys s the	edicai	that initiated events resulting in death) Last		Due to (or es a	consequ	ance of):							
Box		M		d										
	the death certi y the ettending sched for use a	Physician/M	Part II. Other significant conditions o	ontributing to death	hut not resulting	in the un	deriving course give	on in Part I	23h F	lid tobacc		delburto to 1	the cause o	nd aloneth 9
P.O.	- 0 -	hys	Tartin and angimidant contains o	onthouring to death	out not resulting	III UIA UIII	deriving cedsa give	en in raiti.					ably 4⊠1	
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of Vital Records,	e law requires hes been sign je 2 should be	Completed							24a. W	as an auto erformed?	opsy	aval	e autopsy fi lable prior to pletion of ce eath?	0
<u>~</u>	The ta	Con							1	□Yas 2	⊠ No	10	Yes 20	No
N Z	Physician: The	Be	25. Was cesa rafarrad to medical examinar?	Hospital:			3□ DOA Othe		Daath (Check on	ly one)				
	this seld	on: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Data of Inj (Month, D	ury 28b.	Outpatient Tima of Injury	3□ DOA 28c. Injury Work	4 LI NUISIN	ng Home 5 ☐ R 28d. Descri					
Sic	Attending or deeth. ector: After by the fune	cat	2 Accident Investigation 3 Suicida 6 Could not be	9				Yes 2 □ No	00(1)	10:				
	Ital or A	Certification:	4 ☐ Hornicide determined	building, e	tc. (Specily)		et, factory, office			Town, Stat	a)			ber,
	To the Hospital or Attending I within 24 hours after deeth. To the Funeral Director: After completely filled in by the funer	edicai	29a. Cartifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best niner: On the basis of and mannar s	of examination a	ge, death o ind/or inve	occurred at the time estigation, in my op	e, date and ploinion, death o	ace, and due to t ccurred at tha tim	he causa(s na, date an	and mar d place, a	nner as sta and due to t	led. he ceuse(s))
	To the Common	Σ	29b. Signatura and titla of certifier	1.14	2		29c. Licanse	number				(Month, D		
			you the	2104	en	1	1 20	15004		Apr	il o	33, 19	997	
		8	30. Nama and address of person who	complated ceusa of	death (Itam 23a)	(Type, P	rint)	10/12	Churd	nn	. 100	,		
	Sta	0	31. Date filed (Month, Day, Year)	7 M.D. 32. Ragist	104 Minar's Signeture	KOK	0 31.	SAL13	ourg , "	10 0	2/80	/		
	Registra		APR 2.4 1997	July Dord	war Rardal	6								

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended item #26 per physician State of Maryland / Department of Health and Mental Hygiene 4544 4/29/97 _Carroll Co. Certificate of Death 1. Decedanf's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month Day Yaar 25, 1997 April 7:00 AM Truth Naomi Haines /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 500 Jasontown Rd. Westminster Carroll If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 1□M 2 F Yrs. Director 215-20-7641 71 23, Maryland Usual Rasidence of Decedant 10a. Stata 10b County 10c. City, Town or Location 10d. Insida City Limits 28a-f show event, the Medical Examiner must be notified at 1 Yas 2 No Maryland Carroll Westminster Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 234 21158 U.S.A. 2021 Mayberry Rd. death Funeral Nome 2 12. Was Dacedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. Peges 1 and 2 should be filed within 72 hours effer in ent of Heelth and Mental Hygiene. Int: If Item 27 ie marked other than "naturel", or Ite 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yas 2Ã No Specify: Specify: White þ 3 ☐ Widowed 4X Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Housekeeping Hospital 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Malden Sumama) nt of Heelth and Mental H I: If Item 27 is marked oth / or other treumatic even Be Maude Maus John H. Myers 19a. fnformant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Carol DeGroft/daughter 500 Jasontown Rd. Westminster, MD 21158 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Department of H Important: If iter eny Injury or ott once. 1 L Buriai 2 □ Cramation 3 □ Ramoval from Stata 5 Other (Specify) Pleasant Valley Cem. 4/28/97 Pleasant Valley, MD 21. Signatura o Funera@Sarvice Licensea 22. Nama and Addrass of Facility
Hartzler Funeral Home New Windsor, MD 21776 23a. Part1. Enter the disease, or compilications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximata Intarval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final tu melic disaasa or condition rasuiting In death) Examiner Dua to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the tuneral director, page 2 should be deteched for use as the buriat-transit Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaase or Injury that initieted evants resulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 200 No 2 2 No 25. Was casa rafarred to medical Be 26. Piaca of Death (Check only ona) Othar: 4 Nursing Homa Whostdones Wothar (Specify) residence ၀ 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Dey Year) Certification: 27. Menner of Death 28b. Tima of 28c. Injury af Work? 28d. Dascribe how Injury occurred Naturai 2 Accident 5 Panding 2 □ No Invastigation 1 Yas 3 Suicida 6 Could not be

Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Phyelofan: To tha best of my knowledga, daath occurred at the time, dete end place, and due to the causa(s) end manner as steted.

2 Medicaf Examiner: On tha basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to tha cause(s) and mannar stated. 29a. Cartifian 29b. Signatura and fitia of cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Yaar)

a of daath (Itam 23e) (Type, Print)

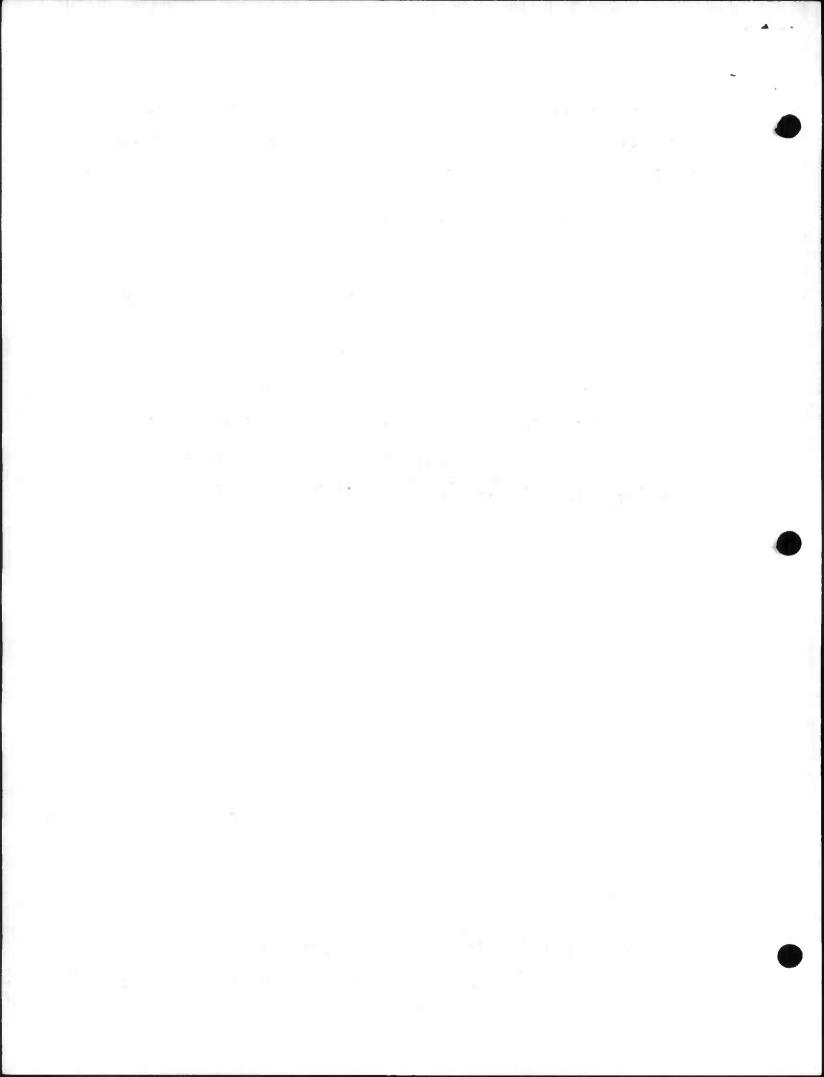
Wal 30. Nema and address of person who so

ustumusle MD

State Registrar

Medical

[REIGI 31. Data filed (Month



State of M.

14545

aryland /	Department	of Health	and Menta	l Hygiene	
,	· Certificate	of Death	ל	Reg No	

1. Decedent's Name (First, Middle, Last) Boni anis

2. Dete of Death

3. Time of Death

Physician /Medical Examiner

Box 68760,

Division of Vital Records, P.O.

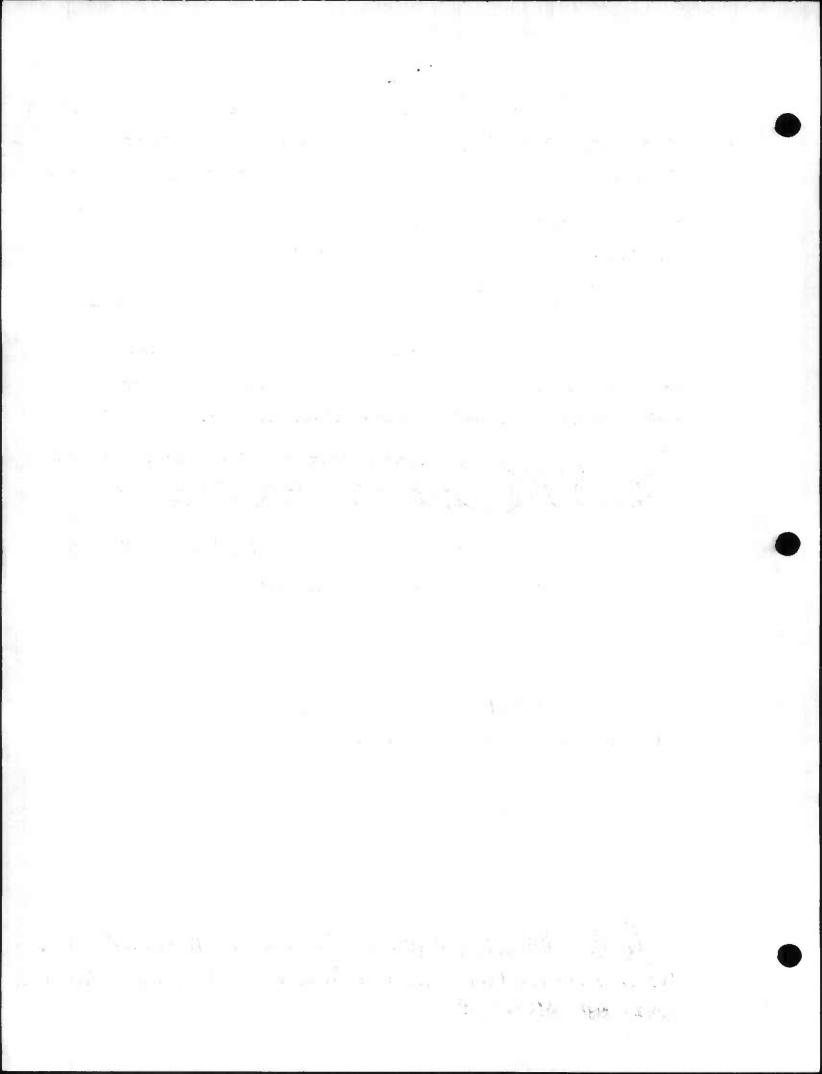
Amonth **Physician** 06 /Medicai 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Fallston Fallston General Hospital If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year Dec. 7, 19 If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funerai** Deys 1 ☐ M 2 💢 F Yrs 68 1928 Director 218-26-3766 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygians. Importment if New 27 is marked other than "natural" and many any flux or other traumatic excess 10a. State 10b. County 10c. City, Town or Location Director Bel Air Maryland Harford 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 21014 Funeral 5 Langford Place 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yas, Giva Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: by Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) Elementary/Secondary (0-12) Coilaga (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Guy McDonald Virginia Mary Thompson 19a. Informant's Name/Relationship (Type, Print) Lowell E. Hackbarth - Husband 5 Langford Place, Bel Air, Maryland 21014 20a. Mathod of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 4/30/97 Mt. Zion U.M. Cemetery 1317 Cokesbury Rd., Abingdon, MD ter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, heart failure. List only one cause on each line. Ventricular Stand Still Immediate Causa (Final disease or condition rasulting in death) ndiomyohath Physician/Medical Examiner • Hospital or Attending Physicien: The law requires that the death certificate be associated 24 hours after death.
• Expersit Director: After this cartificate has been signed by the attending physician and alely filled in by the internal director, page 2 should be dateched for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Diauts Mulitus, Renal Faic þ Vascular de 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☑ No 25. Was cese referred to medicel examiner? Be 26. Placa of Death (Chack only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Couid not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida To the Hosp within 24 ho To the Fune complately f

3:55PM 9. Birthpiace (State or Foreign Country)
W. Virginia 10d. Inside City Limits 1 Yes 2 No 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 20c. Location - City or Town, Stete Bel Air, Maryland 22. Name and Address of Facility
Howard K. McComas III Funeral Home, P.A. Approximate Interval Batwe Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 € No 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 1 Certifying Phyalclan: To the best of my knowledga, daath occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29a. Cartifier Medical (Check only one) 29b. Signeture ar 29d. Date signed (Month, Day, Year) Attending Physician -16444 30. Nama and address of parson who complated cause of death (Itam 23a) (Type, Print)
VIJAY. S. NAIR M.D. 2112 BELAIR ROAD. FALLSTON. MD 21047

State Registrar 31. Date filed (Month, Day, Year) APR 2 8 1997





Stat	le of Maryland / Department of Health and	Mental Hygiene	0.7	11510
	Certificate of Death	Reg. No.	91	14546
Last)		2. Date of Death Month Dev	Voor	3. Time of Death
	11111116	Month Dey	1007	a. CE PM

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if tem 27 is marked other than "natural", or tems 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be notified anonce.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

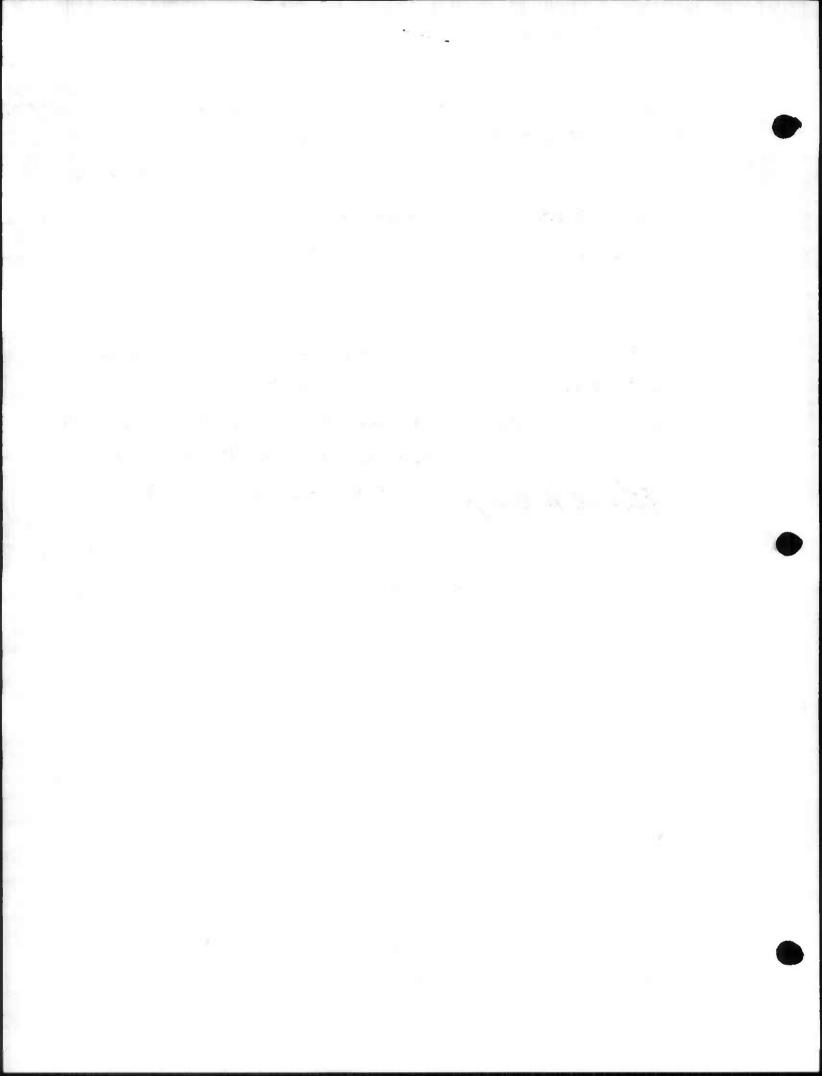
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the bunel-transit

Division of Vital Records, P.O. Box 68760,

n	1. Decedent's Name (First, Middle, La	,							2. Date of Deal Month	th Dey	Yeer	3. Time of Death
al	GREGORY L.		HUC	SHE.	5				April	26	1997	9:55 PM
er	4a. Facility Name (If not institution, giv THE JOHNS HOPKINS						4b. City, To BALTI		cation of Death	4c. County	of Death	
	5. Social Security Number 6. S 220–78–1102 Usual Residence of Decedent	Sex 7. Age	e (In yrs. k	est birtho Yn	Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Dey July 23	Year) 1969	9. Birthpl Count Mary	ece (Stete or Foreign try) land
tor	10a. Stete 10b. County Maryland	8 11			imore C	ity					10	Od. Inside City Limits
lrec	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Coun	try?
0	2020 St. Paul St	reet				21:	218			USA		
by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		S.	13. Was Deced If Yes, spec	ify Cub	dispenic Ori en, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	Ble	ce - America ck, White, e	etc.
Completed	15. Decedent's E (Specify only highest gre Elementery/Secondery (0-12)	ede completed)		16e. De	ecedent's Usua Give kind of wor fe. DO NOT us	l Occup k done e retire	pation during most d)	t of worki	ng	16b. Kind of B	usiness/ind	lustry
E	10	College (1-4or 5	+)]	Propert	y Ma	anagei	5		Bro	keraq	e
Be	17. Father's Name (First, Middle, Last))					18. Mothe	r's Name	(First, Middle, I		-	
0	Lee G. Hughes						Mart	tha I	E. Buell			
	19e. Informant's Name/Relationship (**		19b. M	Malling Address	(Street	end Numbe	er or Rura	I Route Number	, City or Town,	Stete, Zip	Code)
	Martha. E. Hughes	(mother)	1		4 East		n Ave.	., 2	Aberdeen			
	20e. Method of Disposition 1 ☐ Burial 2 ☐ Fernation 3 ☐	Removal from State	ce	metery,	isposition (Nem cremetory or of	her ple	-	1		20c. Location		
	4 □ Donation 5 □ Other (Specifi	y)	R.	A. :	Ferris	& C	ο.	4/3	30/97	West C	heste:	r, PA
	21. Signature of Funeral Service Licer	see B. Bares	ð.		Tarrin Aberde	g-C	argo I	une	cal Home 21001-3	399 P.A.		
	23e. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the deeth.	. Do not	enter the mode	of dyir	ng, such as	cardiac c	r respiratory arr	est,	1	Approximete Intervel Between
	Immediate Cause (Final disease or condition	K	apos	:115	Sarce	ana						Onset and Death 2wceks
Jer	resulting in death)		Due to (or		nsequence of):	1			N			Syeurs
Examiner	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury	0. —			nsequence of):	CIIO) 9(11)
dicai	Cause (Diseese or Injury thet initiated events resulting In death) Last	c	Due to (or	as a con	sequence of):							
cian/Medical	C	d		_							i	
	Part II. Other significant conditions of	ontributing to death bu	t not resul	lting in th	ne underlying ce	use giv	en in Part I.		23b. Dld to	- 1/	ntribute to	the cause of death?
completed by Frigs									24a. Wes a perform	n autopsy ned?	ava	re autopsy findings ilable prior to appletion of cause eath?
Ę									1□ Ye	s 2 No		Yes 2 No
מפ	25. Wes case referred to medical						26. Place	of Death	(Check only on	- '		777
2	examiner? 1 Yes 2 No	Hospital:	nt 2 🗆 E	R/Outpe	etient 3 DO	A Oth	or		ne 5 Reside		er (Specify)
ation.	27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation		Year)	28b. Tim Inju	e of 28	Sc. Injur Wor 1 🗆	yat k? Yes 2⊡l		28d. Describe ho	ow Injury occur	red	
	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc.	ry - At hon (Specify)	me, farm,	, street, factory,	office		2	28f. Location (St City or Town	reet end Numb n, Stete)	er or Rural	Route Number,
medical cel micanoli.	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of niner: On the basis of end manner state	examination	rledge, de on and/o	eath occurred a r investigation,	t the tir	ne, date and pinion, deat	d place, a	and due to the ce	euse(s) end ma ate and piece,	anner as sta and due to	ated. the cause(s)
3	29b. Signature and title of certifier	0				Licens	e number			9d. Date signe		
	Gordon Ken	t Leune 1	Yedlen	1 Pos	ctor	R	E5-0	100		April	26,	1997
	30. Neme and address of person who of GOLDON ICENT LEUNC	completed ceuse of de	ath (Item)	23a) (Ty	pe, Print)	HOSP	ITAL,	BALI	IMORE, M	MARYLA	NO 2	1287
	31. Date filed APR 2. 997199											

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

14547

_					Cer	titicate of	Death		Reg. No.		
	Physic	ian	1. Decadant's Nama (First, Middla, Last) Kenneth Joseph Hu	ıber				2. Data of Do Month	Day	Yaar	3. Time of Death
N	/Medi Exami		4a. Facility Nama (If not institution, give street and number)			-	4b. City, Town, or L	April ocation of Deal			5:45 pm
1	LAUITI	161	Anne Arundel Medical	Cente	er		Annapo:	lis			runde1
	Funeral Director		218-44-5582 1DLM 2DF 5	a (In yrs. last	birthday) Yrs.	If Undar 1 Yaar Months Days		8. Data of Bi (Month, Di Nov 3	rth ay, Year) 1945		laca (Stata or Foraign try)
	land w		Usual Rasidance of Dacadant 10a. Stata 10b. County	10c. City, To	own or Loc	ation				1	0d. Insida City Limits
	a-f sh	tor	MD Anne Arundel	Seve	erna	Park					1 ☐ Yas 2 🔼 No
	or 28	Dire	10e. Street and Numbar			10f. Zip Coda			10g. Citizan of \	What Coun	try?
	s 23s	era	511 Red Oak Drive	Secreta II C	40.11		146	7.16	US		
)20	within 72 hours after death with the Maryland iene. Than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 11∆ Nevar Marriad 2 ☐ Married 1 ☐ Yas 2 ☐ N 1 ☐ Yas 2 ☐ N 1 ☐ Yas 7 ☐ Datas:			Yas Dacedant of Yas, specify Cul	Hispanic Origin? (Spoan, Maxican, Puarto Specify:	Rican, atc.)	Specify	ea - Amaric ok, Whita, Wh	
2-00	2 hou		15. Decadant's Education	10	6a. Dacada	ant's Usual Occu	pation		16b. Kind of Bi	usinass/inc	lustry
21215-0020	within ene. than	Completed	(Spacify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5	5+)		irman	during most of work ad)	ang	Gener	al E	lectric
Maryland	ed la bo	To Be	17. Fathar's Nama (First, Middla, Last) Henry A. Huber				18. Mothar's Nam				rzahn
Mar	and and sm		19a. Informant's Name/Ralationship (Type, Print)				t and Number or Rui				
	Heall Heall hm 2	1	Mildred Huber/mother 20a. Mathod of Disposition	20b. Place	of Dispos	ition (Nama of	Drive,		na Par		
Baltimore,	ent o nt: If		1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify)			atory or other pla Cremato		pr 28 1997	Balti		
alti	permit. F Depertur Importar any Injur		21. Signature of Fungual Service Ligardies	1	22.	Nama and Addr				n .	Home Funeral
	205 2 2		281 Farth Eyer tha disease, though eatins that caused shock, of heart failure. List only the cause on each in	" (נשח		OAKIEC	inie Hwy	., Sev	erna P	rark,	MD 2114
1	Physician										Interval Batween Onset and Death
	/Medical Examiner	/	Immedia Causa (Final cause or condition a. Caud	hopul.	~c~	my A	rrest				20 minuter
	Pa 1	Examiner	b. Resp	Dua to (or as	a consaqu	faril	ure				20 minuter 10 hours 3 hours
o,	certificate be executed ding physician and se as the burlai-transit		Sequantially list conditions if any, leading to immediate causa. Enter Undarlying Causa (Disaasa or Injury that initiated avents	Dua to (or as	a consaqu	ance of):	uad ha	etabali	- Acido	0	3 Lours
68760,	physic The b	edical	that initiated avents rasulting in death) Last	Dua to (or as	a consequ	ance of):	2	21-0011			
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œ	death e atte		Part II. Other significant conditions contributing to death but	ut not resulting	o in the un	dadvino causa o	ven in Pert I	23h Did	tobacco use co	ntribute to	the cause of death?
s, P.O.	requires that the death been signed by the atte hould be deteched for	by Physicia	Insulin Pependent	Piale	tes			1	Yes 2□ No		pabity 4 Unknown
Vital Records,	N 20 20	Completed	Prabetic Keto acid	Losis				24a. Was	s an autopsy ormed?	ava	ara autopsy findings ailabla prior to appletion of causa daath?
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Vita	Physician: The this certificate ral director, peg	Be	25. Was casa rafarred to medical axaminar?			0.	26. Place of Deat	h (Check only	опа)		
o	5 00	: To	1 Yas 2 No riospital. 1 Inpatial 27. Manner of Death 28a. Data of Injur		Outpatiant o. Tima of	3LI DOA			idanca 6 Oth		•)
ion	Attending or death. ector: Atter by the fune	ation	1 ☐ Natural 5 ☐ Panding (Month, Day 2 ☐ Accident invastigation	Year)	Injury	M 1	ork?]Yas 2□No	ZOG. D'AGOIIDO	now injury cocur	60	
Division of	To the Mospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicida 6 Could not be datarmined 28a. Place of Inju	ury - At homa, c. (Specify)	farm, stre	at, factory, office		28f. Location (City or To	(Street and Numb wn, Stata)	er or Rura	Routa Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	edical	29a. Cartifiar (Check only one) 1 Certifying Physician: To tha best of and mannar sta	axamination a	lga, daath o and/or inva	occurrad at tha ti astigation, in my	ima, data and place, opinion, daath occurr	and dua to tha red at tha tima,	causa(s) and ma data and place,	innar as st and dua to	atad. tha cause(s)
	To To the com	Σ	29b. Signatura and titla of certifiar			29c. Lican			29d. Data signe		
			19 MM ms			D39	(54		April	16) 1	777
			30. Nama and addraws of person who complated causa of de John P. Serlen 1705 1	aath (Itam 23a	(Type, P	rint)	chine	Aca .	11 hr	0	(12 / 5
	Sta	te	31. Data filed (Month, Day, Year) 32. Registra	or's Signatura	-1100	7. 111	ghway,	INNO) [1	.0 0	1013
	Registr	ar	MAY 01 1997	Davidson	-Mande	<u> </u>					
DU	IIII de Dan em	-									

Amended #28c, Mod Ple 4/29/97, Allegany County Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14548 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey **Physician** Month HEBB ADALINE FAYE April 25, 1997 10:18 am /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Allegany Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth NOV, 14 Year 1918 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Days Hours 78 Director Yrs 235-70-3171 Usual Residence of Decedent filed within 72 hours after death with the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show mast be notified at MD Allegany Cumberland Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 302 Grand Avenue 21502 Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: r than "natural", or items the Medical Examiner ma Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Marital Stetus 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 21215-0020 1 Yes Z No Completed by Specify white 3X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Peges 1 and 2 should be filed nent of Health and Mental Hygirm: If Item 27 is marked other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William D. Foley Fannie Mae (Nelson) 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If Item 27 is or other tra Short Gap, WV 26753 Ruth Coffman-sister 20a. Method of Disposition
1 Buriel 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete Depertment of Important: If any injury or Forest Glen Cemetery 04/28 Green Spring, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service License 22. Name and Address of Facility
Scarpelli Funeral Home Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediate Cause (Final Metastatic cancer of pancreas disease or condition resulting in death) 10 days Examiner Due to (or as a consequence of): Carcinoma of pancreas 6 months The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es a consequence of) P.O. Box 68760. physician Physician/Medicai the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? the is certificate has been signed by director, page 2 should be detact 2 No 3 □ Probably 4 □ Unknown 1 | Yes Cachexia; History of CABG; History of aortic valve Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? replacement; History of breast carcinoma 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Division 1 Natural 5 Pending Investigation s efter death. 2 Accident 1 Yes 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 D Homicide Hospital To the Hospital within 24 hours e Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a, Certifier 29d. Date aigned (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number Kan 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nus Dr. Ranjithan, 517 Oldtown Road, Cumberland, MD 31. Date filed (Month, Day, Year) APR 25 1997 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14549 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2 Date of Deeth avril ROSE VIOLA HOFFMAN 4e. Fecility Neme (If not institution, give street end number) 4b, City, Town, or Location of Deeth WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number If Under 1 Yeer 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) 1□ M 2√√ Months Deys Yrs. 212-74-1440 95 August 20, 1901 MARYLAND Usuel Residence of Decedent 10a Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND WASHINGTON **BOONSBORO** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8507 MAPLEVILLE ROAD 21713 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 11. Marifel Stafus Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 □ Divorced WHITE Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6 HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) (UNKNOWN) DAMMIE BOWERS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 20614 JEFFERSON BLVD., HAGERSTOWN, MD 21742-4441 RAY HOFFMAN/SON 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) MT. ZION CEMETERY 4/26/97 SAN MAR, MARYLAND of Funerel Service Litensee 22. Name end Address of Fecility 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete fntervel Between Onset end Deeth Immediate Ceuse (Finel diseese or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funerai

Director

28a-f show

9

"naturel", or Items 23e

the Medical Examiner must be notified at

Director

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Completed

Be

the Maryland

death

Baltimore, Maryland 21215-0020

Pages 1 end 2 should be filed within nant of Health and Mental Hygiene. int: If them 27 is marked other than

permit. Pages 1 end 2 a Department of Health ar Important: if item 27 is eny injury or other trau

attending physician end for use as the burial-transit The law requires thet the death certificeta be axecuted Division of Vital Records, P.O. Box 68760, certificate or Attending Physician: death.

Physician/Medical Examiner by Completed Be Certification: To To the Hospital or Attendit within 24 hours effer death. To the Funeral Director: At completely filled in by the fu

								24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 Yes 2 No
	s case referr	ed to medical					26. Place of De	eth (Check only one)	
	Yes 2	No	Hospitel: 1 Inpatient 2	☐ ER/Outpetient	3□	DOA	Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Manne 12 N 2 A 3 S	nner of Death Naturel Accident	5 Pending investigation	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury et Work? 1 Yes 2 No	28d. Describe how injury occur	red
	Suicide Homicide	6 Could not be determined			ef, fac	ory, o	ffice	28f. Location (Street end Numb City or Town, Stete)	ber or Rurel Route Number,
		Cartifying Ph	nysician: To the best of my k	nowledge, death onetion end/or inve	occurr	ed et t	he time, date and piece my opinion, death occ	e, and due to the cause(s) end moured et the time, date end plece,	anner es stated. end due to the cause(s)

29c. License number

State Registrar

Medical

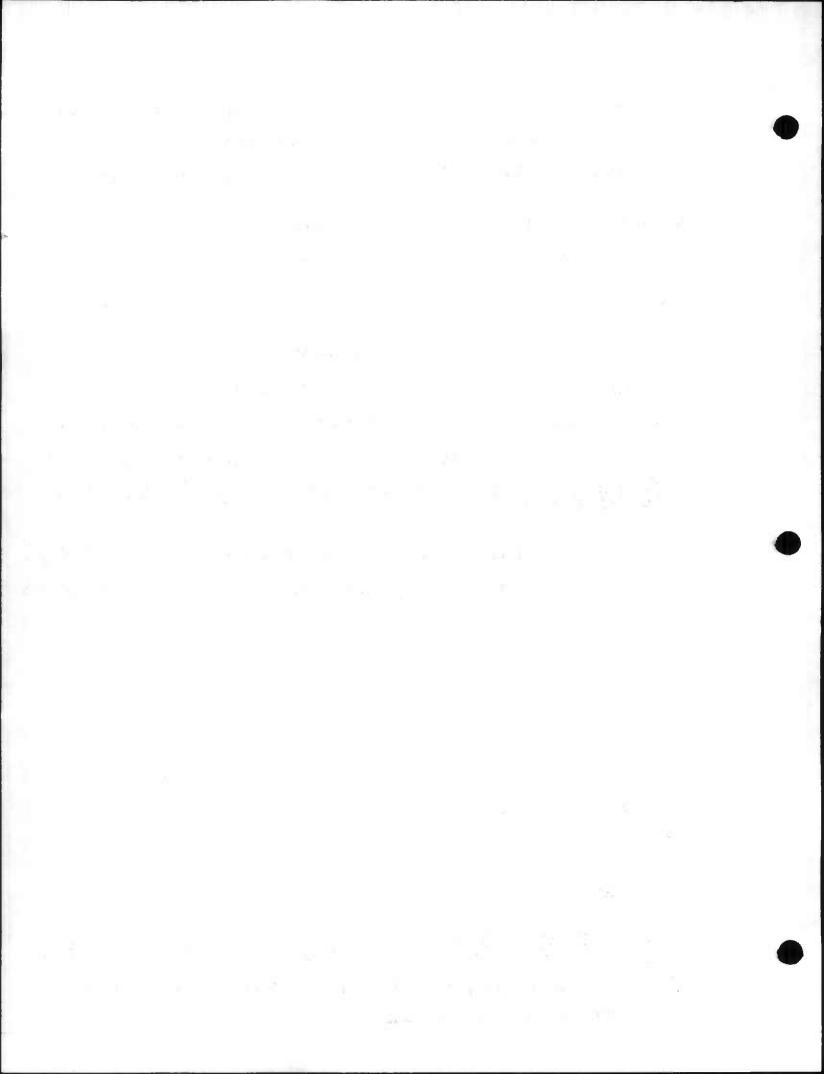
29b. Signeture end title of certifier

30. Name end eddress of person who completed cause of death (flem 23a) (Type, Print)

Hagerstown

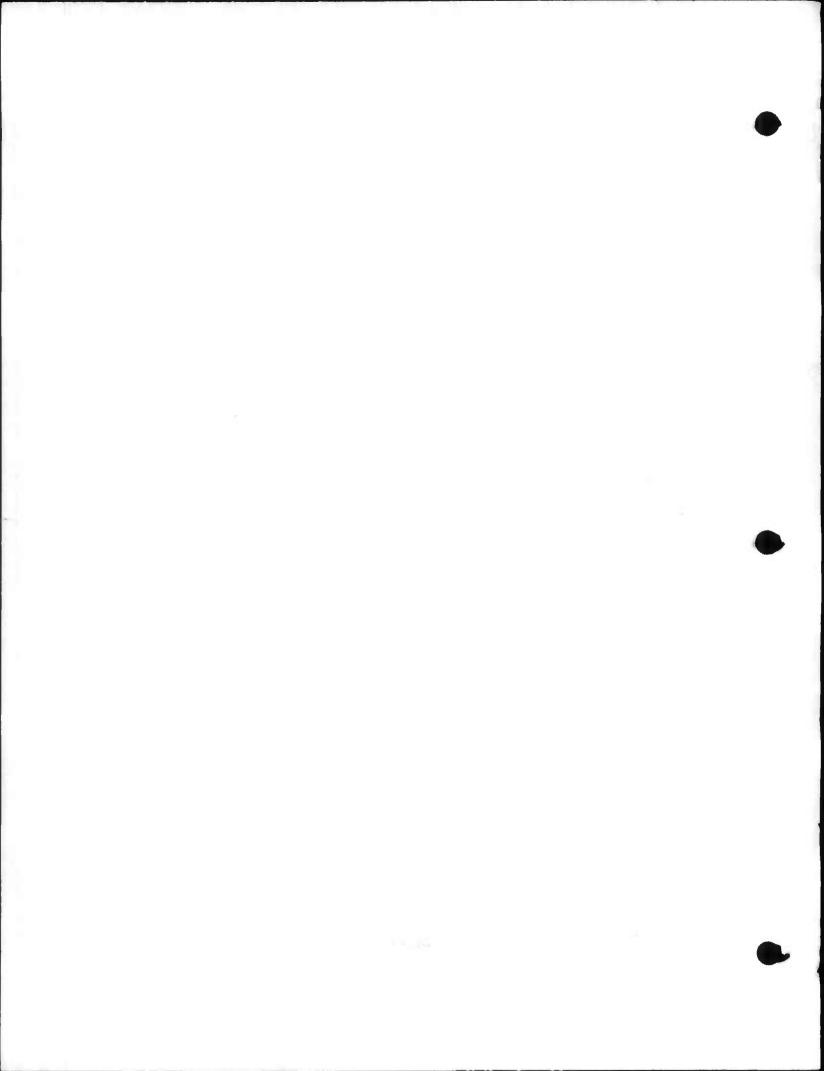
29d. Date signed (Month, Dey, Year)

25, 1997



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should bit the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner much be antified at once
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-x hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funer be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT If item 28 is marked, or litem 23 shows any injury or other traumatic event, the medical evantians must be notified at each

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last) Glenn Matthi	as Heimer	s Heimer					2. DATE OF DEATH April 23, DAY 1997 YEAR				
	4. SOCIAL SECURITY NUMBER 578-24-1880	IF UNDER 24 HRS. HOURS MIN.	HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign									
TOR	9e. FACILITY NAME (# not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH											
DIRECTOR	100. STATE Md. Washington 10c. CITY, TOWN OR LOCATION Hagers town								10d. INSIDE CITY LIMITS? 1 YES 2 X NO			
FUNERAL	21000 Leitersburg	ZIP CODE	1742 10g. CITIZEN OF WHAT COUNT U.S.A			OF WHAT COUNTRY?						
₽	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 X YES	AS DECEOENT EVER IN U.S. ARMED ORCES? 1 X YES 2 NO HI yes, specify Cuben, Mexic 1 YES 2 X NO Spec 1943 - 1945			can, Puerto Rican, etc.) Black, White, atc			RACE — American Indian, Black, White, etc.			
once.	15. DECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12)	ON est of working .CCT	166. KIND OF BUSINESS/INDUSTRY GOVERNMENT									
at once.	17. FATHER'S NAME (First, Middle, Last) AMOS K. Heine	16. MOTHER'S NA			Sumame)	inc						
TO BE	180. INFORMANT'S NAME (Type/Print) Mildred B. Heimer	(Wife)			nd Number or Aurel bwrg Pil							
er must b	20a. METHOD OF DISPOSITION 1 Burlel 2 & Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of complete of surface of complete of surface of complete of surface of s											
al examin	menino x	Davis Funeral Home Smithsburg, Md. 21783										
vent, the medic	23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter tha mode of dying, such as cardiac or reapiratory arreat, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition reaulting in death) Due to (or As A consequence of):											
, or other traumatic event, the medical examiner must be notified at once. ERTIFICATION TO BE COM	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. OUE TO (OR AS A CONSEQUENCE OF):											
shows any injury. : MEDICAL C	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDING COMPLETION OF CAUSE OF COMPLETION OF CAUSE											
AN AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES		UNCERTAI	N X			1 YES 2 NO			
HYSICI	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 ER/Outp	atlent 3 GOOA 4	THER:	• 5 Speldence	v .						
marked, BY PH	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME (M 1 1	RK? /ES 2 NO	28d. DE:	SCRIBE HOW II	NJURY OCCUR	ED			
28 Is TED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	PLACE OF INJURY — At home, farm, streel, fectory, offica building, etc. (Specify)			28f. LOCATION (Street end Number or Rural Route Number, City or Town, Stete)						
ANT: If ite		tCIAN: To the best of my knowl ER: On the beste of examination							nuse(a) and menner as stated.			
IMPORTANT: If item TO BE COMPLE	296. SIGNATURE AND TITLE OF CERTIFIE Way E. Wo	29c, LICENSE NUI	29d. DATE SIGNEO (Month). Day, Year) D238/5 \$\Begin{array}{cccccccccccccccccccccccccccccccccccc									
	354 Mill O	30. NAME AND AUDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 354 Mill St. NOGLUSTOWN, MO 21740 Mary E. Money M.D.										
	31. DATE FILED (Month, Day, Year) APR 2 4 1997	JULIA DRUMBAN	-Reduk									



State of Maryland / Department of Health and Mental Hygiene

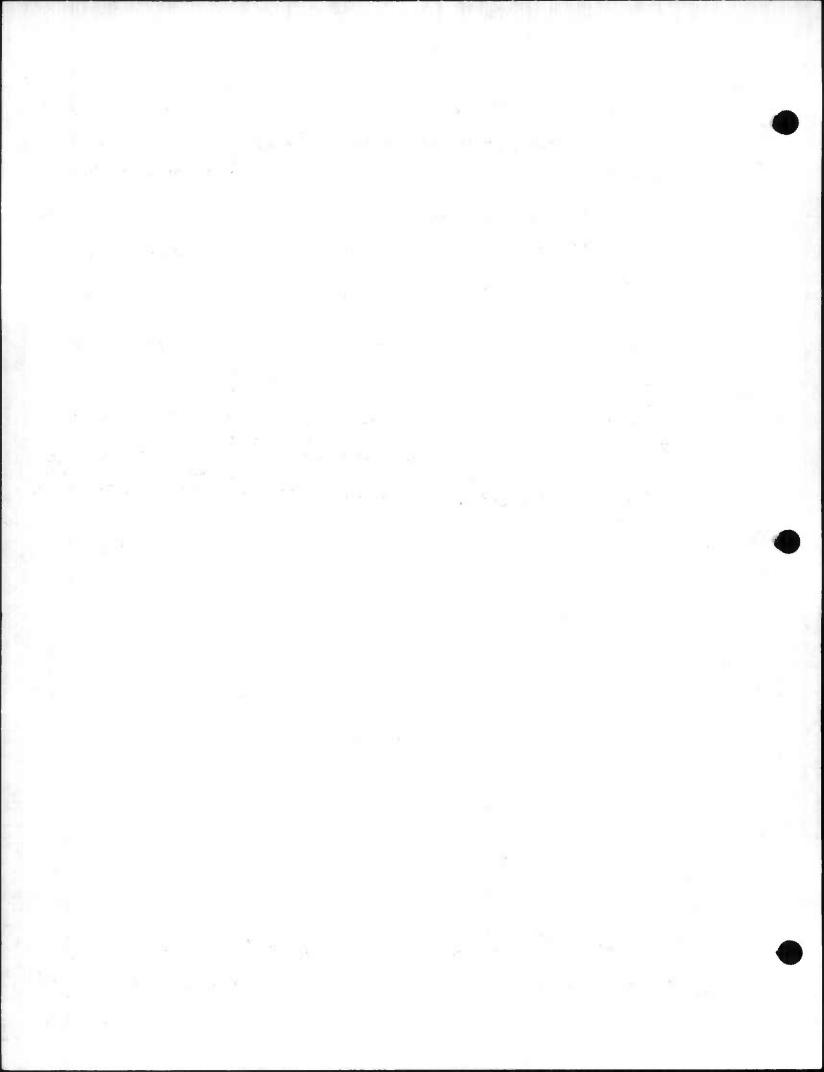
	Iten	1.	8 per PHY Film G748 6-1		ii y icai i				Death	rvieritai r iyg	leg. No.		145	551
			1. Decedent's Nama (First, Middla, Last)							2. Data of Daa Month	th	Veer	3. Time	of Death
Physician /Medical			Charles Julian Hawkins Jr.							April	25, 19	97	8:3	0 A.M.
Examiner			4a. Facility Nama (If not institution, giva						4b. City, Town, or		4c. County	of Death		
			124 Harry Hawkins				1 40		Centrevi		Queen			
	Funeral Director		5. Social Security Number 6. Septing 218-24-4868 Usual Rasidance of Dacedant	7. Aga M 2□F		9 Yrs	Month	ar 1 Yaar s Days	If Undar 24 Hrs Hours Min.	8. Data of Birth (Month, Day	Year) 1928		aca (State ry) land	a or Foreign
	nyland how		10a. Slata 10b. County 10c. City, Town or Location									10	d. Insida	City Limits
	e Ma 8a-f s ztries	cto	Maryland Queen Ar	nes	Cen	trev	ille						1 🗆 Ya	s 2X No
	vith th	Director	10e. Street and Number					Zip Code		1	0g. Citizen of V	Vhat Count	ry?	
	e 23e	srai	124 Harry Hawkins					1617			USA			
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be profiled at once.	by Funeral	11. Marital Status 1 □ Nevar Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedant E Armed Forcas? 1 X Yas 2 No If Yas, Giva Yaar or Datas:		S. 1		ecify Cub	Hispanic Origin? (Sean, Maxican, Puar Specify:	pecify Yas or No- lo Rican, atc.)	Blac	e - America ek, Whita, a :: Blac	itc.	
5-0	72 hornanda	Completed	15. Decedant's Edu (Specify only highast grade	cation a complated)	18a. Decedent's Usuai O (Giva kind of work of			suai Occup	pation during most of wo	rkina	18b. Kind of Businass/Industry			
121	han "	щр	Elementary/Secondary (0-12) Collega (1-4or 5			5+) Iifa. DO NOT usa retire			(d)					
7	illed v Hygie ther t		12th 17. Fathar's Nama (First, Middla, Last)			Cra	ne Op	erato		na (First, Middla,	Constr		n	
ani	d be i	o Be	Charles Julian Ha	wking Sr						T. Goul		a)		
ary	shoul mark meti	2	19e. Informant's Neme/Ralationship (Ty		•	19b. M	elling Addra	ss (Stree	and Number or Re			State, Zip	Code)	
	aith a 27 is r trat		Roxie O. Hawkins/	wife					awkins La					17
ore,	of Har		20a. Mathod of Disposition		20b. PI	ace of Di	sposition (A	lama of			20c. Location -			
Baltimore,	Page nent c int: if		1 ☑ Burial 2 ☐ Cramation 3 ☐ R 4 ☐ Donation 5 ☐ Othar (Specify)	amoval from Steta			own C		,	4/29/97	Gouldto	wn. M	ld.	
alt	Departr Departr Imports any Inju		21. Signature of Funaral Sarvine License	10			22. Nama	and Addra	ass of Facility					
—	20529		//			\Rightarrow			Smith Fun 1687, E			216	01	
	Physician /Medical Examiner		23a. Part1. Enter tha diseasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrest, Approximate Interval Between Caucal Conset and De Caucal									etween		
68760,	lificate be executed g physician and es the buriel-transit	edical Examiner	Sequantially list conditions, if any, leading to immediata causa. Entar Undarfying Causa (Disaasa or injury that initieted evants rasulting in death) Last				sequence of							
Box	nding usa e	2												
	daeth a atte ed for	sicia	Part II, Other significant conditions con	tributing to death but	t not resu	Iting in th	a undarivino	ceuse oi	van in Pert I.	23b. Did to	bacco usa co	ntribute to	the caus	e of death?
P.O.	uiras that tha daath cer signed by tha attendin Id be datached for usa	by Physician/W	Rectal Carcinoma.							96 2□ No			Unknown	
Records,	aw requisite been 2 should	Completed b								24a. Was a perform	n autopsy med?	ava	re autops liable prio apletion o eath?	y findings r fo f cause
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Vital	ysician: The last cartificate he director, page	Be	25. Was casa rafarred to medical axaminar?							ath (Check only or	(9)			
	Physician: rthis cartific ral director,	2	1 1 1 1 1 1 2 2 1 1 1 0	ospital: 1 Inpatlan	-	R/Outpa		DUA		loma 5 Raside)	
u	Aftar funar	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Panding	28a. Data of Injury (Month, Day	Year)	28b. Timi Injur	У	28c. Inju Wo		28d. Dascribe h	ow Injury occurr	ed		
-	To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: Aftar th completaly filled in by the funeral	Certification:	2 Accident invastigation 3 Suicida 6 Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)						Tras Z No	28f. Location (Street and Number or Rural Routa Numb City or Town, Stafa)				ımber,
	To the Hospital of within 24 hours a To the Funeral D completely filled in	edical (29a. Certifiar (Check only and) 2 Medicat Examin	ician: To the best of er: On the basis of a and manner state	axamineti	/ledga, da	ath occurre	d at tha ti	ma, data and piace opinion, death occu	, and dua to tha corred at the time, d	ause(s) and ma ete and place, s	nner as eta and dua to	ited. the cause	o(s)
	within To the comp	M	29b. Signatura and put of put				2	9c. Licans	se number	2	29d. Data signed (Month, Day, Year)			
	-		• Ushnu	1				D	3988-	7	4/2	28/97		
		İ	30. Neme and eddrass of person who co	mpleted cause of de	eth (Item)	23a) (Ty	pe, Print)	MN	2.1		1-			
			509 Idlewild	Auc	70	isto	7) (コン	2160	1				
	Sta Registra	_	31. Data filed (Month, Day, Year) ADD 9 9 100	32. Ragistrar	's Signati	ure 🛶	0.							

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death **Physician** JOHN APRIL 26 -1997 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Chinion If Under 24 Hrs. 8. Da OUILEAN Grand NINCE If Under 1 5. Social Security Number 8. Date of Birth (Month, Day, Year 6. Sex 7. Age (In yrs. last birthday) Year Birthplece (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Deys Hours 60 Director May 16, 1936 Virginia 229-48-4782 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director Oxon Hill Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 20745 1449 Sutherlin Ave items 23a United States death Funeral 11. Merital Status 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indien, permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel!. A page. Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes PorNo If Yes, Give Year or Dates: black 1□ Yes XX No by Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lumber Company Laborer 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ella Crews 2 Ollie Inge 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6709 Southfield Road, Fort Washington, Md 20749 Ronnie Inge 20b. Place of Disposition (Neme of cemetery, crematory or other place) May 2, 1994 20a. Method of Disposition 20c. Locetion - City or Town, Stete XX Burlal 2 Cremation 3 Removel from State 4 □ Donation 5 □ Other (Specify) Danville, Virigina Highland Burial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the in sease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear railure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and the burial-transit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): USB BS been signed by the a should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 11XYes 2 No 3 Probably 4 Unknown Division of Vital Records, þ Completed 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? page 2 20 No 1 Yes 1 Yes 2 No director, 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home Certification: To 1 Inpetient 2 ER/Outpatient 3 DOA 5 ☐ Residence 8 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Medicai 29a. Certifier 1 critifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. completely The resulting Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mainten as stated.

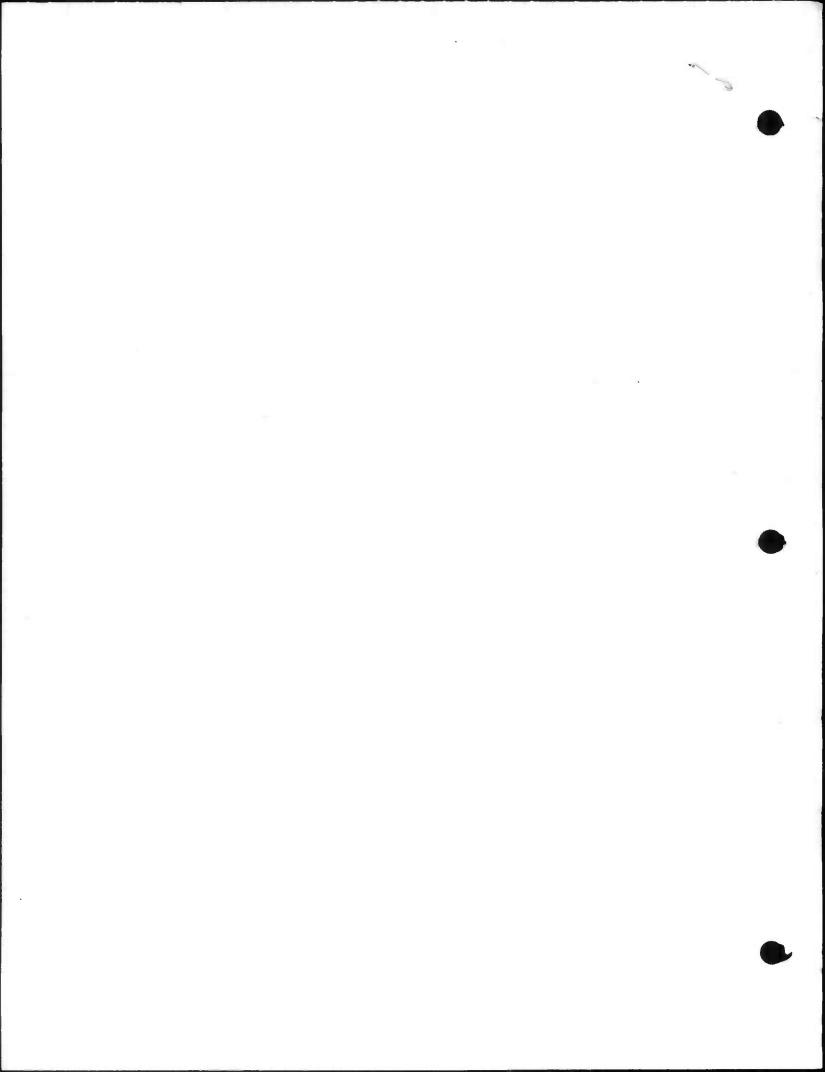
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) 2073, 7700 SSAM OLD MD 3 0 1997 32. Registrer's Signature State Dubi Davolson Randall Registrar



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEN	E	14000		
Ů,	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	3. TIME OF DEATH			
	Marie B.		Jone	S		April 22		1 P. M		
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTI	HPLACE (State or Foreign		
	171-05-2745		35 YRS.			Dec. 23,19	Per Per	nna.		
ac	9a. FACILITY NAME (If not institution, give in				R LOCATION OF DEA	ATH				
DIRECTOR	(home) 6105 Tayl	or randing Re	۸.	G1	rdletree		Worces	ter		
REC	10a. STATE 10b. COUNT	TOWN OR LOCAT			tod. INSIDE CITY					
	Md. Wor		Girdlet	ree			t YES 2 NO			
FUNERAL	100. STREET AND NUMBER 6105 Taylor Land		101	. ZIP CODE 2182	.9	U.S.				
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. A						IIC ORIGIN? (Specify Yes or No. 14, RACE - America			
ВУ Е	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES		If yes, sp	2 NO Specify:	k, White, etc.				
						Specify: white				
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	(Give kind of we life, Do NOT use	ork done during mo	N st of working	16b. KIND OF BUSINESS/INDUSTRY				
12	Elementary/Secondary (0-12)	College (1-4 or 5+)	h	omemake		OV	vn home			
S.	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	TE (First, Middle, Maiden :				
BE C	Robert Breitens	tein			Berth	a ? Brei	itensteir	ı		
5	19a. INFORMANT'S NAME (Type/Print)					oute Number, City or Town				
-	Mary Lou Parsons					Hill, Md.				
	20e. METHOD OF DISPOSITION 1 M Burlal 2 Cremation 3 Rem	oval from State 20b	PLACE AND DATE OF others, crematory or others.	POISPOSITION (Na	me of		CATION — City or To			
,	1 & Burlel 2 Cremation 3 Removel from State Cemetery, or other place									
	Pt	PA	•							
_	23. PART i. Enter the disesses, or	0 00//	West Dans			Snow Hill,				
	shock, pr heart fellure. IMMEDIATE CAUSE (Finsi disease or condition resulting in death)	s. Cast only ona cause on a	ach lina.	4	bed	Fally		Approximats Interval Batween Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
AL C	PART II. Other significent condition	a contributing to death b	ut not resulting in	the underlying	cause given in P	Part I. 24a. WAS AN		. WERE AUTOPSY FINDINGS		
S						PERFORI		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PHYSICIAN: MEDIC							X	1 YES 2 NO		
Ä	DID TOBACCO USE CONTI				UNCERTAIN					
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	OTHER:						
HYS	1 YES 2X NO 27. MANNER DE CEATH	1 Inpetient 2 ER/Outp	28b, TIME		5X Rasidence 8	Other (Specify) 28d. DESCRIBE HOW IN	I III DV OCCUPED			
BY PI	1 Pending 2 Accident Investigation	(Month, Day, Year)	ULINIU	RY WO		200. DESCRIBE NOW IN	JOHY OCCOMED			
	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, etc. (Spec	— At home, term, at	reet, tectory, office		28t. LOCATION (Street as City or Town, State)	nd Number or Rural I	Route Number,		
COMPLET	29a. CERTIFIER (Check only 1 KCERTIFYING PHYSI									
one) 2 MEDICAL EXAMINER: On the beals of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(e) at										
296. SIGNATURE AND TITLE OF CENTIFIER 29d. DATE SIGNED (Month, D.										
2	30. NAME AND ADDRESS OF PERSON WH						Cele	2		
7	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	NUME	ce 9	20	een 81)	(Selen	y mi		
	APR 23 1997	Julia Davidson	Randall							



State of Maryland / Department of Health and Mental Hygiene

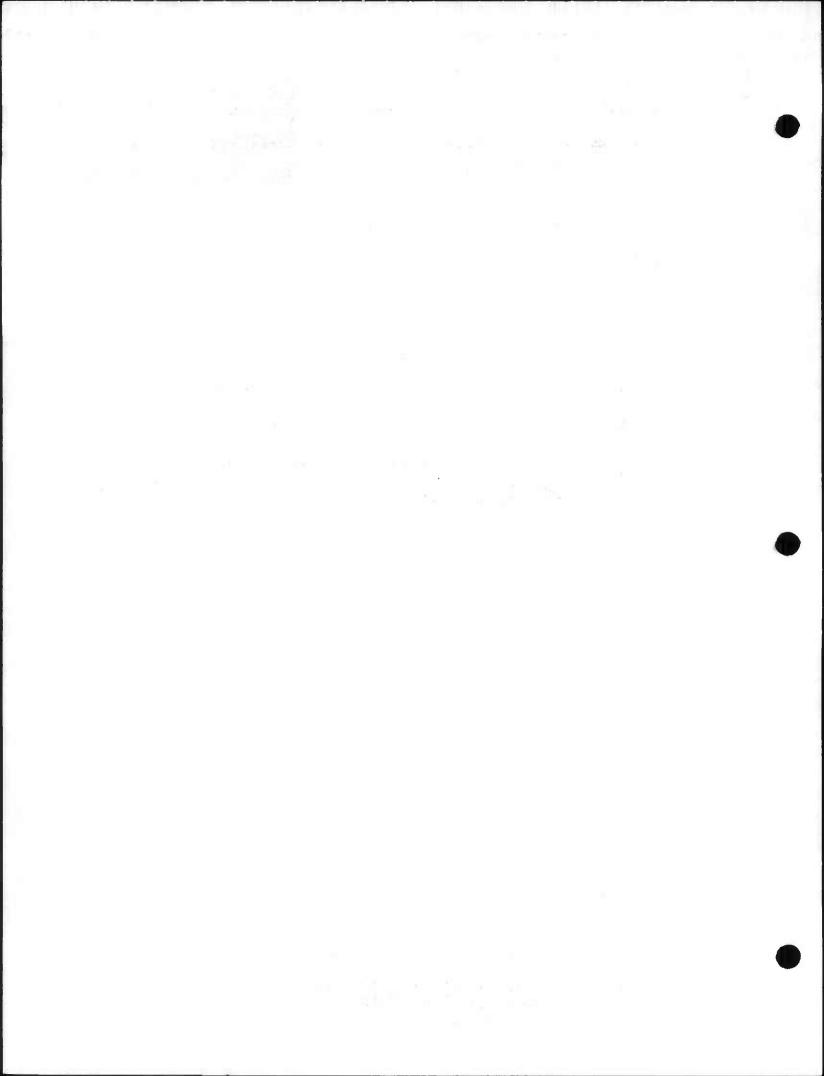
Certificate of Death 1. Decedent'a Name (First, Middle, Last) 3. Tima of Death 2. Date of Death Month **Physician** M.KATHERINE **JOHNSON** 25,1997 April 12:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury center, Genesis ElderCare Salisbury, Md. Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 25 F 86 Yrs. Director 218-05-8120 Maryland Usuai Rasidence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or Funeral 1517 Ocean City RD 21801 U.S.A. 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Giva ☐ Yaar or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Ricen, etc.) Race - Amarican indian, Black, White, etc. be filed within 72 hours after 1 ☐ Naver Married 2 ☐ Married ò 21215-0020 1 ☐ Yes 2 ☑ No Specify: by Specify: White 3 Widowed 4 Divorced "natural". Completed 15. Decedent's Education (Specify only highest grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Buainess/Industry other than Elementery/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Auto. Dealer Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of hand Mental F. 7 is man Be Pages 1 and 2 should hent of Health and Ment William Johnson 2 traumatic Margaret 19e. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau onise. 20b. Placa of Disposition (Name of cemetery, cramatory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 X Buriai 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donation Porterville Cemetery 4-28-97 Stockton, MD 21. Signature of Eunarai Servica Licensea 22. Name and Address of Facility 705 E. Main St. Salisbury, MD 21804 lala Bounds Funeral Home Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Examiner TENSZEM The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last and Box 68760, attending physician Physician/Medical Due to (or as a consequance of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by the 3 Probably 4 Unknown 1 | Yee 2 | No ment W by Completed 24a. Was an autopsy parformed? 24b. Were eutopsy findings available prior to completion of cause of death? After this certificate 1 Yes 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 212 No Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Naturai 2 ☐ Accident death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: illed in by the 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) \$ 29b. Signature and title of cartifier 29c. Licensa number 29d. Date-signed (Month, Day, Year) n au) D-39813 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) MICHAEL ATKINS, M.D. 1104 HEALTHWAY DR.SALISBURY, MD. 21804 Regional Signification Reveal

DHMH 16 Rev 6/95

State Registrar

APR 281997



State of Maryland / Department of Health and Mental Hygiene

				Olato of Mary		Certificate of		,	Reg. No.	97	14555
	B1		1. Decedent's Neme (First, Middle, Last)					2. Dete of De Month	ath Dey	Year	3. Time of Death
	Physici Medie/		Birdie FI	LLA		Johnson		April	24,199		10:55 PM
}	Examir		4a. Facility Name (If not institution, give s				4b. City, Town, or Lo	ocation of Deati	4c. County	of Death	
			Salisbury Center:		dercar		Salisbury		Wicon	iico	
	Funeral Director		214-42-7900	7. Age (In	yrs. last birth	Months Days		8. Dete of Bir (Month, De September	th y, Year) er 26,1907		ace (Stete or Foreign ry) vland
	and w		Usuat Residence of Decedent 10e. Stete 10b. County	10	c. City, Town	or Location				10	Od. Inside City Limits
	Menyl	0	Marvland Wicomi	co	Delm	ar					1 X Yes 2 □ No
	28a	Jec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Count	iv?
	3a o	<u>-</u>	1028 Chestnut Mar	nor Apt. 1		21	.875	ı		USA	
	be filed within 72 hours efter death with the Meryland itel Hyglene. d other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be incufied at	Funeral Director	11. Marital Status 1 1 □ Never Married 2 □ Married	I2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No	in U,S.	13. Wes Decedent of I If Yes, specify Cub		ecify Yes or No Rican, etc.)		e - America k, White, e	
21215-0020	o since	by	3 ₩ Widowed 4 □ Divorced	If Yes, Give Year or Detes:		1 □ Yas 2 🙀 No	Specify:		Specify	· W	hite
5-0	72 ho netur	Completed	15. Decedent's Educ (Specify only highest grede	ation	16e. C	ecedent's Usuai Occu	pation	ina	16b. Kind of Bu	isiness/Indi	ustry
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Maryland	2 - 2 - 2	Be	17. Father's Name (First, Middle, Last) Zadack	Wells			18. Mother's Name Viola	e (First, Middle) Prisci			
Š	should be nd Mentel marked o	2	19a. Informent's Neme/Ralationship (Typ.		10h 8	Melling Address (Stree				arson	
S	7 18										Dode)
စ်	- 포 를 든		Deborah L. Core/] 20e. Method of Disposition		Ob. Place of D	E. Chestn Disposition (Name of		elmar,	MD 2187 20c. Location -	5 City or Tov	wn, Stete
9	Pages nent of int: If its iry or o		1 St Burlai 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amovel from Stete		cremetory or other pla s Cemetery		/29/97	Salisb	urv.	MD
Baltimore,	permit, Pages Depertment of Important: If it any injury or o		21. Signature of Puneral Service License	e M(105/	22. Name and Addre					
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	Physician		shock, or heert failure. List only on	e ceuse on eech lina.							Intervel Batween Onset and Death
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Ğ,	be ey ician buria	aiE	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.								
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ň	v requires thet the deeth cert been signed by the ettendin should be detached for use	Physician/N	Part II. Other aignificant conditions cont	tributing to death but no	et reculting le t	ha uadarivina asusa ai	iven in Pest t	23h Did	tohecoo uee co	atribute to	the cause of death?
J.	by the	hys	Downs And And And And And And And And And And	nouting to death out no	n resulting in t	ne undenying cause gi	ven in Pan t.	1 🗆	/	3 □ Prob	
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Vital	ysician: is certific director,	Be (25. Was casa referred to medical exeminar?				26. Placa of Daat	h (Check only	ona)		
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	tending Ph leath. tor: After th the funeral	ion:	27. Manner of Deeth 1 Netural 5 □ Panding	28e. Date of Injury (Month, Day Yea	ar) 28b. Tin	iry Wo	ork?	28d. Describe	how injury occurr	ed	
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\geq	or Attending F effer death. I Director: After d in by the funer	Certification:	4 Homicida determined	building, etc. (S)	At nome, tarn pecify)	i, straet, fectory, office		City or To	Street end Numb wn, State)	er or Hurai	Noute Number,
_	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in		29e. Certifier 17 Certifying Physi	ician: To the best of my	/ knowledge	leeth occurred at the ti	ime dete and place	end due to the	cause(s) and me	nner es et	eted
	• Hoan 124 h	edical	(Check only 2 Medicat Examinations)	er: On the basis of axai end manner steted.	mination end/	or investigation, in my	opinion, daath occur	red et tha time,	date and place,	and due to	the cause(s)
	To the To the	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signer	i (Month, L	ay, Year)
		5	Mus	TUX			3981	3	4/-	5/	97
,			30. Nama and address of parson who con	npleted causa of daath	(Itam 23a) (T	ype, Print)	-101				
			MASKER	vs.		1104 Healt	hway Dr.,	Salish	ury, MD	218	04
	Sta		31. Dete filed (Month, Day, Yeer) 199	7 Hegisty two	ademic Co.	dall					
	Registr	ar	AI II N 0 133	0							

State of Maryland / Department of Health and Mental Hygiene 97

							Ce	rtificate o	f Death			Reg. No.		
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	Physic /Medi		MART	E	Jac	ITSO N	1 .				April		177	. 7-50PM
}	Exami		4a. Facility Nama (If I						4b. City, To		ocation of Dea		y of Death	
			LIBERTY					If Under 1 Yes						
	Funeral Director		5. Social Security Nui 212-18-64	33	Sax 1 M 2 F	7. Aga (In y	rs. last birthday, Yrs.	Months Day		Min.	8. Data of B	Year 20	9. Birthi Cour DOVE	placa (Stata or Foraign ntry) R, DEL.
	pue *		Usual Rasidence of D	ecedant 0b. County		100	City, Town or L	ncation						10d. Insida City Limits
	ath with the Merylen 23a or 28a-f show ust be notified at	Director	MD.	BALTIM	ORE		ALTIMOR							1X Yes 2 □ No
	F 20 E	Sire	10e. Street and Numb					10f. Zip Coda				10g. Citizen of	What Cour	ntry?
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	frems	Funeral	11. Maritai Status		Armed F	cedant Evar in orces?	U,S. 13.	Was Decedant of if Yas, specify Cu	f Hispanic Or uban, Maxica	igin? (Spen, Puarto	ecify Yas or N Rican, atc.)	o- 14. Ra	ce - Amari	can fndian, . atc.
	72 hours after death with the Meryland natural; or items 23a or 28a-f show fical Examiner must be notified at	þ	1 Nevar Married 3 Widowed 4		1 ☐ Yas If Yas, G Yaar or [2.☑ No iva		1□ Yas 2Å N					ty: BLA	ACK
)	n 72 hours "natural", ed cal Ex	etec	(Specify	5. Decedant's E	ducation)	16a. Dece	dant's Usual Occ kind of work don DO NOT usa reti	upation	st of worki	ina	16b. Kind of B	Jusiness/In	idustry
	filed within Hyglene. ther than "	Completed	Elamentery/Second			(1-4or 5+)	DOMES		red)			HOUSE	KEEPE	ER
num hand	s 1 and 2 should be filed within 72 hours after des f Health and Mentel Hyglene. ttem 27 is marked other than "natural", or flems other treumstic event, the Medical Examiner in	To Be C	17. Father's Nama (F	rst, Middle, Last GEORGE S	,				18. Moth	ar's Nama	, ,	a, Maidan Sumai NER ALLE		
	1 end 2 sho Health and I em 27 is me wher treums		19a. informant's Narr BARBARA	RINDV	(Type, Print) AUGHTEF	₹		ng Addrass (Stre					n, Stata, Zip 21210	
	00 -		20a. Mathod of Dispo 1 ☐ Burial 2 ☐ 4 ☐ Donation 5	sition Cramation 3 [☐Ra <i>m</i> oval from	20b	p. Place of Dispo cematary, cre	osition (Nema of matory or other p	lece)		Data	20c. Location	- City or To	own, Stata
Dalimore,	permit. Pag Department Important: I sny Injury o		21. Signature of Trune		Big	fley		2. Nama and Add	erscy	Rd	OLLEY I	MEMORIAL		
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	fing Physician: h. After this certific funeral director,		27. Menner of Death		28a. Data	of injury	28b. Tima o					how injury occu		97
	Attending For death. ector: After by the funer	atio	1 ☑Natural 2 ☐ Accidant	5 Panding invastigatio		nth, Day Year	fnjury		onk? □Yas 2□	No				
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	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edicai C	29e. Certifiar 1 (Check only 2 one)	Certifying Ph	ninar: On tha b	a best of my k easis of axami	nowledge, daat nation end/or in	h occurred et the vastigation, in my	time, dete er r opinion, des	nd place, a	and dua to the	a causa(s) and m , data and place,	enner as a	steted. to the cause(s)
	o the office of the o	₩.	29b. Signatura and tit	a of certifiar	3.70			29c. Lica	nsa nu <i>m</i> ber			29d. Data signe	ed (Month,	Day, Year)
	- > - 0	/	11-	-Shan -	.1 ,			DI	9 60	8.		April	8,	1997.
			30. Nama and addras:				am 23a) (Type,	Print)	Col	(cr	iter	Bolin	400	1997 .
	Sta	ate												
	Regist		31. Data filed (Month,	HLK TP	1991 3	yelia d'ai	velsor Ran	lall						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate	of .	Death		Re	g. No.	1	1-1001
	Dhami	,	1. Decedent's Neme (First, Middl	e, Last)			1				2. Dete of Deetl Month	•	Yeer	3. Time of Death
	Physic /Medi		HALLIE QUIN	N TURNER	JAMIS	ON					April 28			2:15 PM
	Exami		4e. Fecility Neme (If not institution	n, give street and nu	imber)			4	4b. City, Town		cation of Deeth	4c. County	of Deeth	
		,	1209 West Jar	rettsvill	le Rd.				Fores		Hill		Harfo	ord
	Funeral		5. Sociel Security Number	6. Sex 1 ☐ M 2X F	7. Age (In yrs			Year Devs	if Under 24 Hours	Hrs.	8. Dete of Birth (Month, Day,	Year)	9. Birthp	olece (Stete or Foreign
	Director		215-32-9429	10 W 2817	96	5 Yrs.					April 29			ryland
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1	288	Director	10e. Street and Number	TOTA		FOL	est Hil				10	og. Citizen of	What Cour	ator?
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-	T 2	Funeral	11. Maritel Status		adent Ever in U	J.S. 13.	Wes Deceder			? (Spe	cify Yes or No-			can Indien,
0	e i		1 Never Married 2 Marr	Armed Fo	orces?		If Yes, specify	Cube	en, Mexican, P	uerto F	Rican, etc.)		ck, White,	
02		þ	3X Widowed 4 □ Divorced	If Yes, Gi	ve ev		1□Yes 25	No	Specify:			Specif	Bla	ick
21215-0020	of a should be within 12 fours after beauti with the maryland th and Mental Hygiene. T is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Extrinner must be not if ad at	Completed	15. Deceden			16e. Dece	dent's Usuel (Decup	ation	6 sacradein	1	6b. Kind of B	usiness/înc	dustry
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Bal	Department of Important: If any injury or once.		21. Sameture of Funere/Service	Licensee			2. Name and A			as T	II Fune	ral Ho	me. P	Δ
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n i	ed fo	Physician	Pert II. Other significant condition	ne contributing to de	eath but not res	sulting in the u	inderlying cau	se giv	en in Part I.		23b. Dld tol	oacco use co	ntributa to	the cause of death?
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DIVISION or Attending	fter dea frector in by the	Certification:	4 Homicide determ	ined 286, Place	of Injury - At hing, etc. (Speci	ome, farm, st	reet, factory, o	ffice		2	8f. Location (Str. City or Town,		oer or Rura	I Route Number,
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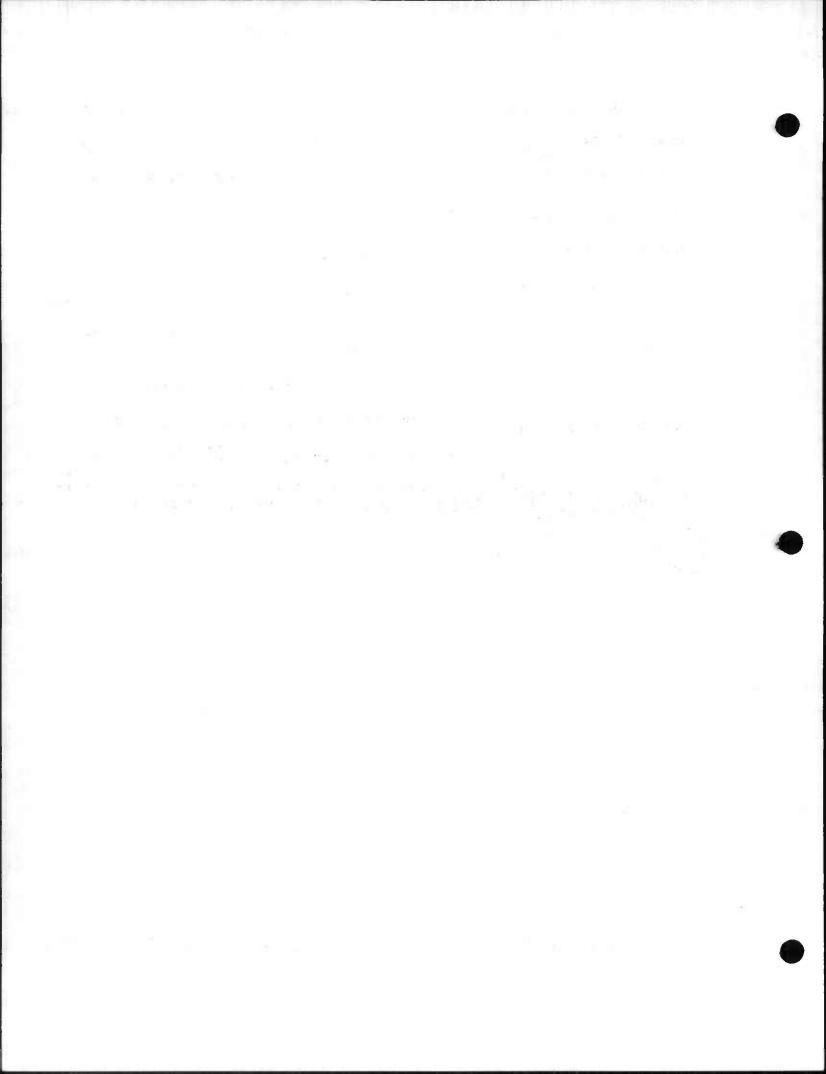
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J	Physici /Medi		Eldredge Frankl	in Jones				April 2	7, Day 1997	Year	7:07PM
	Examir		4a. Facility Nama (If not Institution, give	street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
			24 Swan Street				Aberdeer	n	Harf	ord	
	Funeral Director	Г	5. Social Security Number 6. St 252–52–1105	ax 7. Aga (In	63 Yrs.	If Under 1 Year Months Days	If Undar 24 Hrs.	8. Data of Birth (Month, Day,	Year)	9. Birthpi Coun	laca (Stata or Foreig
			Usual Rasidanca of Dacedant		0.3			Nov. 13	, 1933	Geor	.gra
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pu	2 should be filed withing and Mental Hygiene. Is marked other than aumatic event, the Mental than the Mental t	Be (17. Fathar's Nama (First, Middla, Last)				18. Mothar's Nam	a (First, Middla, A	Maiden Suman	a)	
yla	Ment Ment arked	2	Joseph F. Jones				Mellie I	E. Oxley			
Aar	2 sh end is m		19a. Intorment's Name/Reletionship (7	ype, Print)	19b. Mailin	g Address (Stree	t and Number or Rui	ral Routa Number	, City or Town,	State, Zip	Code)
	CENL		Elizabeth M. Jone		24 St	van Stre	et, Aberde				
lor	907		20a. Mathod of Disposition 1 Was Burlal 2 □ Cramation 3 □		Ob. Place of Dispo- cematary, cren				20c. Location -		
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Bal	permit. Peg Department Important: It any Injury o		21. Signature of Funeral Service Licens	100		. Nama and Addr	ass of Facility argo Fune:	ral Home	. P.A.		
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			23a. Part1. Entar tha disaasa, or comp shock, or haart failura. List only c	ilications I at causad tha ona caus on each lina.	daath. Do not ante	ar tha moda of dy	Ing, such as cardiac	or raspiratory arra	ast,		Approximata Intarval Batween Onsat and Death
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68760,	te be yslcie	Icai	that willated events	CDua	to (or as a consequ	uenca of):					
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	the deeth certificate be executed by the attending physician end sched for use as the burial-transit	Physician/I	Part II. Other significant conditions co	ntributing to death but no	ot rasulting in the ur	ndarlying causa g	ivan In Part I.	23b. Dld to	bacco use co	ptributs to	the causs of death
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no	ding h. After fune	tlon	Natural 5 ☐ Panding	28a. Dete of Injury (Month, Day Ye	ar) Injury	M 1	ork? Yas 2 No	200. Describe no	w injury occur	eu	
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Ö	after after Directory	Certification:	4 Homicida	building, atc. (S				City or Town			
	To the Hospital or Attanding i within 24 hours after death. To the Funeral Director: After completely filled in by the fune		29a. Cartifier Certifying Phy	sician: To the best ot m	y knowledga, death	occurred at tha t	ima, data and place,	and due to the ce	euse(s) and ma	innar as st	ated.
	in 24 the Ft. plete	edicai	(Check only one) 2 Medical Exam	Iner: On the basis of axa and mannar stated.	mination and/or inv	astigation, in my	opinion, death occur	red at the time, da	ate and place,	and dua to	tha cause(s)
	To the To the comple	Σ	29b. Signatura and titla of certifiar	11	1	29c. Lican	sa number	25	9d. Data signe	d (Month, I	Day, Year)
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			30. Nama and addrags of person who c	ompleted causa of daath	(Itam 23a) (Type, I	Print)		X .			
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12. Regular's Signature

State of Maryland / Department of Health and Mental Hygiene

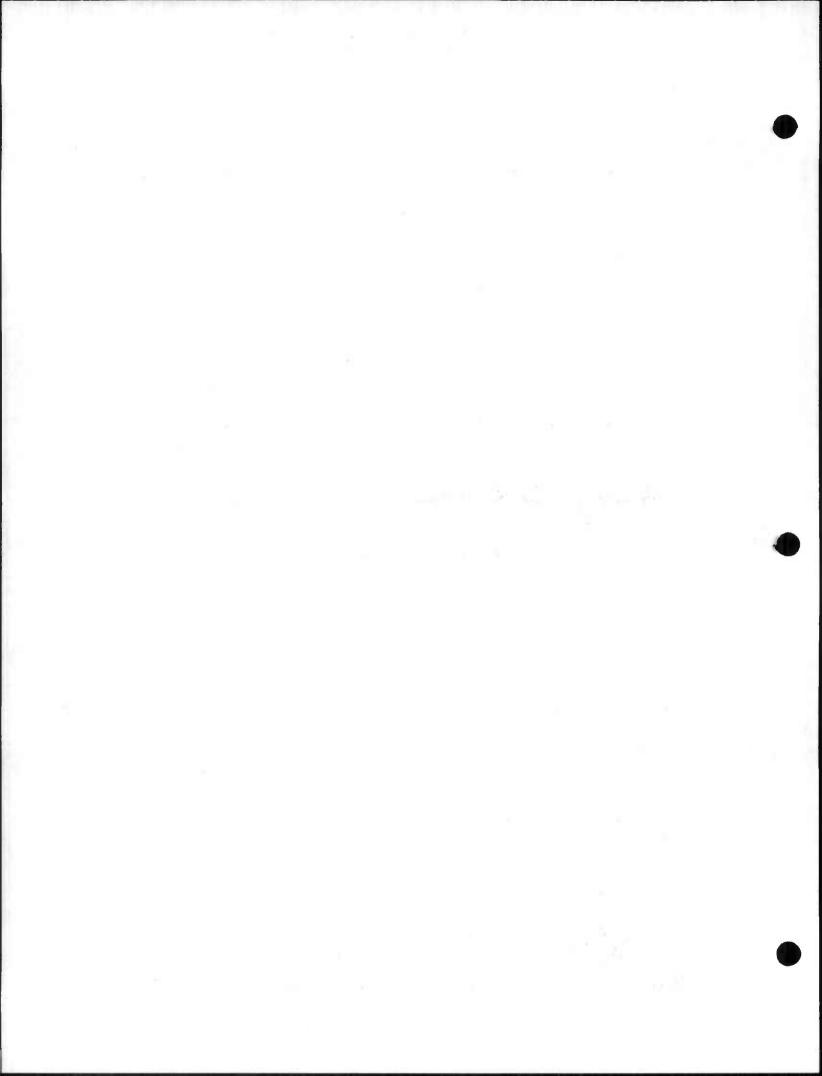
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г	Dharaia		1. Decedent's Name (First, Middle, La	st)						2. Dete of De	eth	Van	3. Time of	f Death
	Physic /Medi		Onas Delton	Jones						April	25, 1	9 9 7	10:5	2 a.1
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			506 Joy Circle					Glen			Anne	Arui	ndel	
	Funeral Director		5. Social Security Number 6. S 467-30-1687 Usuel Residence of Decedent	Sex 7. Age (In yi		Months			Min.	8. Dete of Birt (Month, Da) June 11	h y, Year) 1924	9. Birthp Cour Texa	place (State of htry)	or Foreign
	tand		10a. Stete 10b. County	10c.	City, Town	or Location						1	Od. Inside Ci	ity Limits
	he Mary 28a-f sh curred	Director	MD Anne Ar	undel (Glen	Burni							1 ☐ Yes	250 No
	ath with 1	ral Dir	10e. Street and Number 506 Joy Circle				p Code 106	0			10g. Citizen of USA			
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. I health and Mental Hygiene. I health and Mental Hygiene. I health at the marked other than "natural", or hems 23 or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Maritel Stetus 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Detes:	U,S.	If Yes, spe	city Cu	Hispanic Ori ben, Mexicer Specify:	gin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)		ce - Americ ock, White, fy:		te
5-0	72 ho	ted	15. Decedent's E	ducetion	16e. C	Decedent's Usu	ei Occi	petion	t of workin		16b. Kind of B			
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pu	be filed tal Hygid d other svent, the	Bec	17. Fether's Neme (First, Middle, Last,				-	18. Mothe	r's Name	(First, Middle,	Maiden Sumai	me)		
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Maryland	2 sho and I is me		19e. Informent's Name/Retetionship (Type, Print)							r, City or Town		Code)	
	and and n 27		Eleanor Jones	/wife				rcle,	Gle	n Bur	nie, M	ID 21	.060	
Baltimore,	permit. Pages 1 and Department of Health Important: If frem 27 any Injury or other tr		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif	Dameural from Chata	cemetery,	Disposition (Na crematory or lawn	other pl	ace) .Gard	ens 1	pr28	Marr:		wn, Stete	, MD
	Physician /Medical Examiner	Examiner	289 Part 1. Enter the disease, difficond shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying	a. Due to	9 (Or as a co	t enter the mo	ce	tchie	Hwy cardiac or	respiretory er	verna rest,	Park	Onset end I	ween
ox 68760,	sath certificate be execut attending physician and for use as the burial-tran	Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a co	nsequence of):	81							
Bo.	0 0 2	sicia	Part II. Other significant conditions of	ontributing to death but not r	esulting in t	he underlying	cause o	ivan in Part I		23h. Did t	obacco use co	entribute to	the cause of	of death?
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Records,	e law requines has been sign pe 2 should be	Completed b								24a. Was perfor	an autopsy med?	avi	ere autopsy f allable prior t mpletion of o death?	to:
	产 養里	Co								101	es 200 No	10	Yes 20	No
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Division	After	ation	27. Mariner of Death 1 DNatural 5 ☐ Pending 2 ☐ Accident investigation	531	28b. Tin	ne of ury M	28c. Inji Wi	aryant ork?]Yes 2∐1	80 127	8d. Describe h	ow injury occur	red		
DIVIS	To the Hospital or Attenwithin 24 hours after deal You the Funeral Director: completely tilled in by the	Certification:	3 Suicide 6 Could not be determined	building, etc. (Spec	city)		8			City or Tow				ber,
	To the Hospital or within 24 hours after To the Funeral Direction	edical	29e. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	yalclan: To the best of my kr niner: On the basis of exeminand manner stated.	nowtedge, on netion end/	deeth occurred or investigetion	et the t , in <i>m</i> y	ime, dete en opinion, deel	d piece, er th occurre	nd due to the o	euse(s) end m dete end plece,	enner as st and due to	eted. the ceuse(s	;)
	To the total	ž	29b. Signature and title of certifier					se number			29d. Dete signe			
)			30. Name end eddress of person who	Completed cause of death (th	om 22e\ /T-	(ne Print)	D	3951	05		April en Bu	27	199	7
			Yudhish Man		BIT 238) (T)	ype, Print)	th	Ny #	202	L Gl	en Bu	mi	e Mi	061
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** Month JOY CE Spare MABLE 3:15 AM /Medical 4a. Fecility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BACTIMORE HOSPITAL OF STUTION RE BACKMONE 01 5. Social Security Number If Undar 1 Year If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Aga (In vrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 218-42-4948 1 M 2XF Days Yrs. Director MARCH 10 1910 MARYLAND Usual Rasidance of Decedant filed within 72 hours efter death with the Maryland ns 23a of 25an comment of must be notified at 10e State 10b. County 10c. City. Town or Location 10d. fnsida City Limits MARYLAND ANNE ARUNDEL 1X Yas 2 No Director ANNAPOLIS 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 23 DORSEY AVENUE 21401 by Funeral US Reme 11 Marital Status 12. Was Decedant Evar in U,S. Armed Forces? Wes Decedanl of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. traumatic event, the Medical Examiner 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 ☐ Naver Merried 2 ☐ Married 21215-0020 6 1 ☐ Yas 2 ☑ No Specify Specify: BLACK 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast greda completed) I Hygiene. Elementery/Secondary (0-12) Collaga (1-4or 5+) 4th DOMESTIC OUT SIDE THE HOME Baltimore, Maryland 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) . Pages 1 end 2 should be fill timent of Health end Mental Heart: If item 27 is marked othiury or other traumetic even Be DANIEL W. SMITH ISABELLA SMALLWOOD 19e. fnformant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) PEGGIE COOKE (GRANDAUGHTER) 23 DORSEY AVENUE ANNAPOLIS, MD. 21401 20b. Place of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata cematary, crematory or other place)
ANNAPOLIS MEM. GARDENS PEBurial 2 ☐ Cramation 3 ☐ Removal from State Depertment of important: If any Injury or 5/6/97 ANNAPOLIS, MD. 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licenses 22. Name end Addrass of Facility WM . REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer failural List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** /Medical Immediate Cause (Final CASTROINTEDNAL BLEED) diseese or condition rasulting in daath) Examiner Dua to (or as a consequence of) Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initieled evants rasulting in daath) Last the buriel-tren pue Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or es a consaquanca of) for use es Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. deteched 23b. Did tobacco use contribute to the cause of death? signed by 1 | Yes 2 | No 3 ☐ Probably 4 Unknown DISPHSE þ should be Completed 24a. Wes an autopsy performed? 24b. Ware autopsy findings eveilable prior to been completion of cause of daath? After this certificate has Attending Physician: Be 25. Wes case rafarred to medical 26. Piaca of Daath (Check only ona) axaminer? 1 Yas 2 No Hospital: 1 Dunpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 2 filled in by the funeral 27. Manner of Deeth Deta of Injury (Month, Day Year) Certification: 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 5 Pending invastigation Watural death. 1 Yas 2 🗆 No 2 Accident or Attend after death Director: 3 ☐ Suicide 6 Could not be detarmined 28a. Pleca of Injury - At home, ferm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital o within 24 hours af To the Funeral DI completely filled in Certifying Physician: To the bast of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

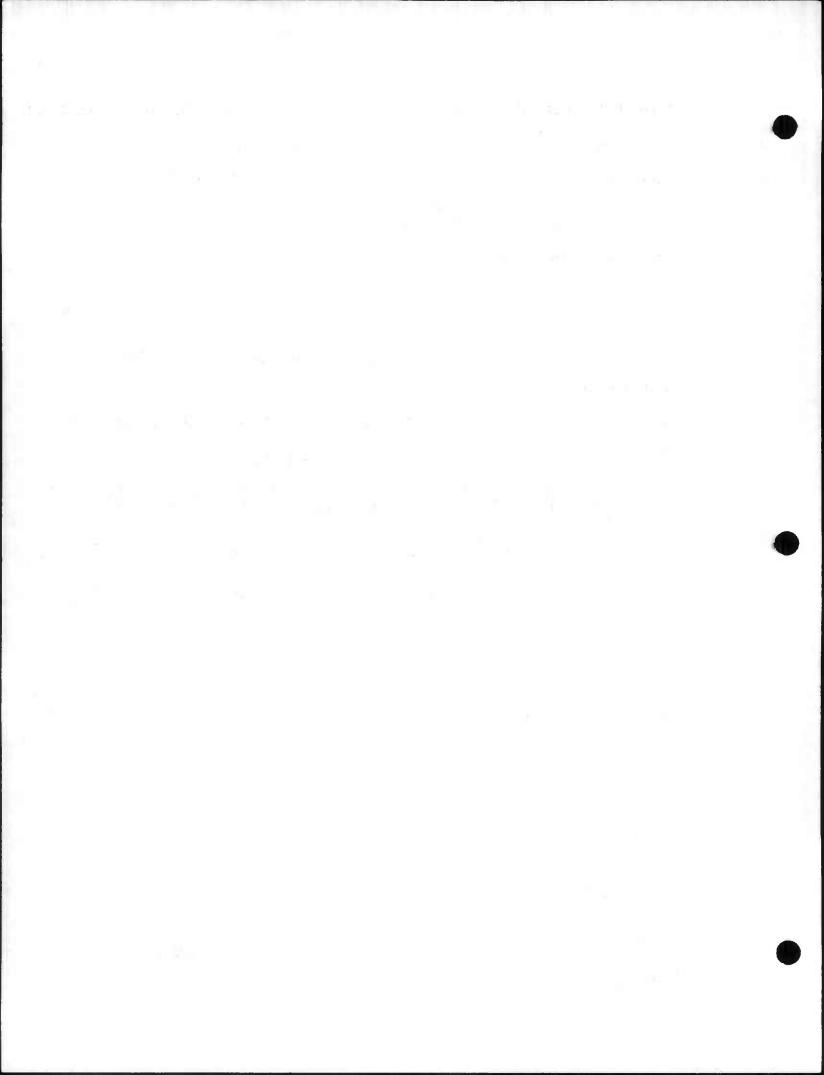
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) end manner stated. Medical 29a. Cartifier (Check only one) 29b. Signetura and little of certifian 29c. Licansa number 29d. Date signed (Month, Day, Year) AS2402341469032 person who completed cause of death (Itam 23a) (Type, Print) BADHOLE; WOI WEST BENEDOKE; F. Cffing SMAT HUSPITA OF 32. Ragistar's Signatura 31 Data filed (Month, Day State MAY 0 2 1997 Registrar



State of Maryland / Department of Health and Mental Hygiene Q 7

						Cert	tificate o	f Death		Reg	. No.	,	14001
	Discola	,	1. Decedent's Neme (First, Middla, La	St)						te of Deeth	Day	Yeer	3. Time of Deeth
	Physic /Medi		ROBERT STEPHEN JI	ENKINS						RIL 23			0520 A.M.
	Exami		4a. Facility Name (If not institution, giv	a street end number))			4b. City, Tow	n, or Location		4c. County		024031111
	Funerai Director		Sacred Heart Hosp 5. Social Security Number 6. S 215-20-5547 Usuel Residence of Decedent		ge (In yrs. lest bir	thday) Yrs.	If Under 1 Ya Months De		Min. (M	te of Birth onth, Day, y	'ear)	Cou	plece (Steta or Foreign
	pue *		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Loca	ation					1	10d. Inside City Limits
	death with the Maryland irms 23a or 28a-f show irms to northed at	Director	Maryland Gai	crett	Gran	tsvi	lle 10f. Zip Code	9		100	ı. Citizan of \		1 ☐ Yes 2 🖔 No
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	n 72 hours after death with the Marylen "neturel", or Items 23s or 28s-f show edical Examiner must be nortified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married	12. Wes Decedent Armed Forces? 1 Yes 2	?		as Decedent of Yas, specify C	of Hispenic Origi uban, Mexican,		as or No- elc.)	14. Red	ce - Americ ck, White,	can Indien, etc.
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mai yiaild	d la b	To Be	17. Fether's Neme (First, Middle, Last) Ralph Jenkins					Anna S	's Name (First, Stepher		ilden Sumen	na)	
3	and and	ľ	19a. Informent's Name/Reletionship (eet end Number					Code)
5	l and tealth m 27 her ti		Leota G. Jenkins	/wife				ermany I					21536
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	permit. Departr Importa any inje		21. Signeture of Funerel Servica Licar			22. No.	Name end Add	drass of Facility	Homas.	РΔ.	179 N	Mille	r Street,
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יבחוסססט	w requires that s been signed b 2 should be dete	Completed by							24	ta. Wes en performa	eutopsy id?	av	ere autopsy findings allabla prior to empletion of causa deeth?
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	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one) 1 ☐ Certifying Ph. 2 ☐ Medical Exam	yalcian: To the best niner: On the basis of end menner st	f examination en	, death o	occurred at the	time, date end y opinion, deeth	plece, and du occurred et th	e to the cau ne time, date	se(s) and ma end place,	anner as a and due to	stated. the cause(s)
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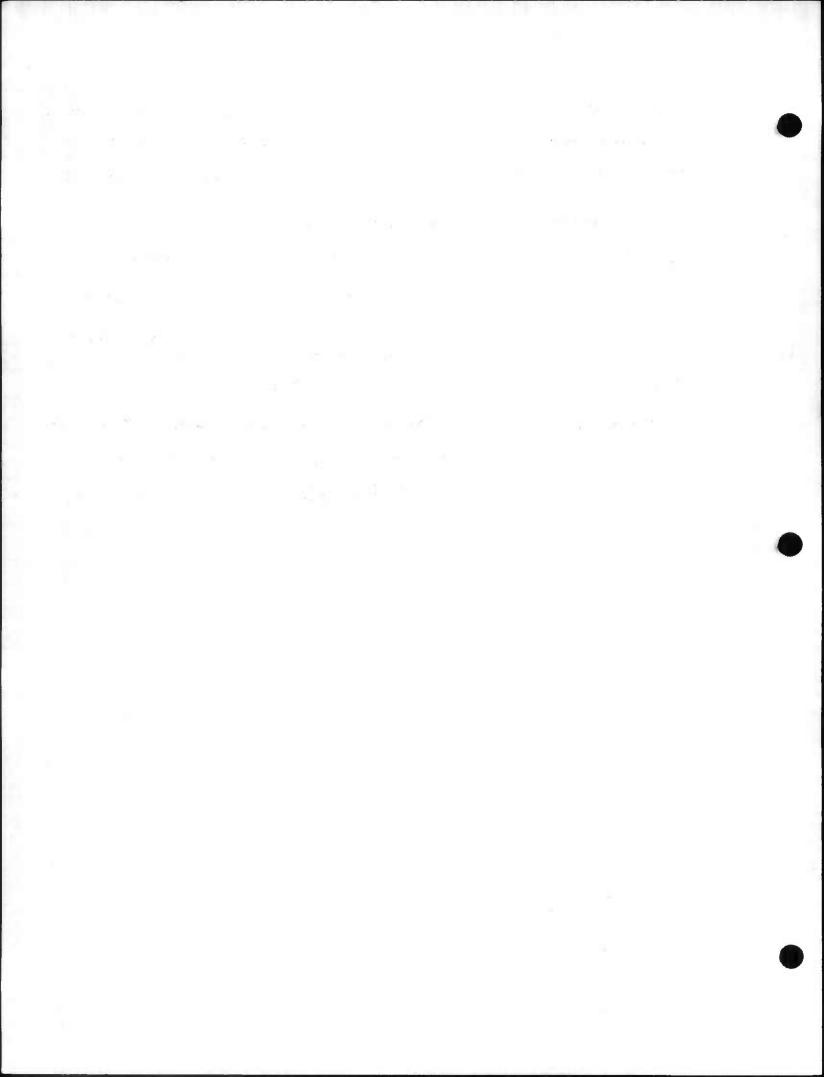
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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J	Physic /Medi		MARTHA ADAMS	JUDY						APRIL	22.	1997	8:34 A	M.
	Exami		4e. Facility Name (If not institution, give	street and number)				4b. Cit	y, Town, or	Location of Deet		County of Death		
			MEMORIAL HOSPIT	TAL				C	JMBER!	LAND	1	ALLEGANY		
	Funeral Director		5. Social Security Number 6. Security Number 220–07–6234 Usual Residence of Decedent	C	(In yrs. last	birthdey) Yrs.	If Under 1 Ye Months Da		nder 24 Hrs ura Min			9. Birth Cou 7 WEST	piace (State or Fintry) VIRGIN	
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Maryland	0386	o Be	CARL R. ADAMS						JULIA	HARTMAN				
ary	2 should and Men is marke reumatic	-	19a. Informant's Name/Relationship (7	ype, Print)	1	9b. Maillr	ng Address (Str	eet end N	umber or F	lural Route Numb	er, City o	Town, State, Zi	o Code)	
	9 7 7 4		RUSSELL ADAMS / E	BROTHER		ROUT	E 2, BO	x 192	2-B, 1	KEYSER,	WEST	VIRGINI	A 2672	5
Baltimore,	2 5 -		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetlon 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ceme	stery, cren	sition (Neme or natory or other BY CEME)	piece)		Dete 4/26/97		cation - City or T		
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens	Church		UE	Neme end Ad CHURCH	FUNE	RAL K	DME, INC	West	VIRGINI	A 2671	9
			23a. Pert1. Enter the disease, or comp shock, or heart tellure. List only of	dications thet caused t	the death. D	!						7110111	Approximate Interval Between	
	Physician /Medical Examiner	ner	Immediate Cause (Final disease or condition resulting in death)	. Card	La C		Ac	4	57	ole			Onset end Des	ath
Box 68760,	death certificate be executed e attending physician and ed for use as the burlal-transit	in/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C	Oue to (or as			Y						
	that the death ed by the atte datached for	Physician/	Part II. Other significant conditions co	ntributing to death but	not resulting	g in the ur	nderlying cause	given In I	Part I.	23b. Did	tobacco	uss contributs t	o the causs of d	leath?
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jo	Attending Ph r death. ector: After th by the funeral	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Dey	rear)	Injury		Yes	2 🗆 No					
Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, (Specify)	farm, str	eet, factory, offi	ce		28f. Location (City or To	Street and wn, Stete)	d Number or Run	al Route Number	:
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying Phyone) 2 Medical Exem	relcian: To the best of iner: On the basis of and manner state	xamination	ige, death and/or inv	occurred at the restigation, in m	time, da y opinion	e and plac death occ	e, and due to the urred at the time,	ceuse(s) date end	and manner es : pleca, and due t	steted. o the cause(s)	
	withir To th comp	Me	29b. Signature and little of certifier	11	^		29c. Lic	ense num	ber		29d. Date	e signed (Month,	Day, Year)	
	1		11/000	5 CV			1	165	79		9	1-29-97	7	
	unix		30. Napre and address of person who c	ompleted cause of de	ath (Item 23)	E) (Type;		, , ,						
	N BOX		G. Haddad, M.D.	- 566 Sou	th Mir	eral	Street	, Ke	yser.	WV 267	26			
	Sta Registr		31. Date filed (Month, Dey, Year) APR 3 0 1997	Registrar	's Signature	robally		,						



ELMA May 4. 7997 ONES OUISE /Medical 4b. City, Town, or Location of Deeth 4o. County of Death 4e. Fecility Neme (If not Institution, give street end number) Examiner ommunity 7. Age (In yrs. lest birthdey) 85 Yrs. Lanham loctors Hours Min. 8. Date of Birth Month, Day, 07-23 Sociel Security Number If Under 1 Year 6. Sex **Funeral** 219-07-992 1 M 2 KF Months Deys Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at MD Director DOMERSET ames 10e. Street and Number 10f. Zip Code 11080 robeits Kally 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ⊠No if Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired)

OOK 15. Decedent's Education Elamentary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled Department of Health and Mental Hygis Important: if Item 27 is marked other any Injury or other traumatic event, it 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental h Maggie loadivine harles 19e. Informant's Name/Relationship (Type, 19b. Mailing Address (Street end Number or B. Daughter 12800 Suffers Bowie Louiso Pages 1 20e. Method of Disposition
1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramovel from State 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Dete 5-10-97 Green Comotuy 4 ☐ Donetion 5 ☐ Othar (Specify) Cres 22 Name and Address of Facility Anthony E. Wald Funcial Home 30639 Hampden Are Princess Anne, 21. Signature of Funeral Service Licenses 23a. Pert1. Enter the disease of complications that caused the shock, or haart failure. List only one cause on each line. **Physician** /Medical Immedieta Ceuse (Finel diseese or condition rasulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Records, P.O. Box 68760 Physician/Medical å attending Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ă à 2 Completed page 2 certificate Division of Vital 25. Was case referred to medical Be Hospital: 1€Qnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 25 No 計算

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1. Decedent's Neme (First, Middle, Last)

Physician

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Deeth

Prince

10:05AM

Doige

10d. Inside City Limits

1 ☐ Yes 2 KNo

10g. Citizen of What Country? 14. Rece - American Indien, Bleck, White, etc. Black Specify: 16b. Kind of Businass/Industry Dunta Omeisat 18. Mother's Name (First, Middle, Meiden Surnama) W: ISON MD 20720 20c Location - City or Town, State Jalisbury mno, ND 21853 Approximete Interval Between Onset end Deeth 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□Yes 2KNo 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) 28d. Describe how injury occurred 26c. Injury at Work? 1 Yes 2 No 281. Location (Street and Number or Rural Route Number, City or Town, State) certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

27. Manner of Death

1 60 Natural

2 Accident

3 C Sulcide

29a. Certifier

4 Homicide

MAY 06 1997

gnature and title of certifier

5 Pending investigation

€ Could not be

ne and address of person who completed cause of death (item 23a) (Type, Print) INGA

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Director

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To the Hospital or within 24 hours all To the Funeral Di

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacadent's Nama (First, Middla, Last) SR. 2. Data of Death 3. Time of Death Day **Physician** rauss 4b. City, Town, or Location of Death a4, 1997 th 4c. County of Death WILLIAM 0010 /Medical 4e. Facility Name (If not institution, give street and number) **Examiner** PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO Hours Min. 8. Date of Birth (Month, Dey, Year) 7 - 2 - 26 5. Social Security Number 214-22-5859 If Under 1 Yaar Months Days 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country)
 D **Funeral** Days 70 Director Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Maryland nant of Health and Mental Hygiene.
Int: If Itam 27 is marked other than "naturel", or items 23s or 28s-f show my or other traumetic event, I'm Medical Examiner mant be nutified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. WICOMICO WILLARDS Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 36098 LUMBERYARD RD. 21874 USA Completed by Funeral 12. Was Decedant Evar in U,S. Armed Forces? 102 Ves 2 □ No If Yes, Give Year or Dates: 50 - 52 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. Black, Whita, atc. 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) MANAGER BANKING 17. Fether's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) FERDINAND KRAUSS LILLIAN WIMMER 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 36098 LUMBERYARD V. JEAN KRAUSS RD. WILLARDS, Mp, 21874 20b. Plece of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Paurial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) Department of Important: If any injury or DALE CEMETERY 4-26 WHALEYVILLE, MD. 22. Nama and Address of Fecility ULLRICH FUNERAL HOME BERLIN, 23a. Part Entar tha diseasa, or com complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onset and Death one cause on each line Physiclan /Medical Immediate Cause (Final disease or condition resulting in deeth) LNFARCTION MYOCARDIAL Examiner Due to (or as e consequence of): CORONARY DISEASE The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last the buriel-tran Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, HYPERTENSIUS HEART Physician/Medical Due to (or as a consequence of): use es CARDIO PULMONARY ALREST Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ete hes been signed by page 2 should be detec 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24e. Wes an autopsy performed? 24b. Were autopsy findings aveilable prior to complation of cause of death? After this certificete 1 Yes 2 LINO 1 Yes 2 No or Attending Physician: director, 25. Was case rafarred to medical Be 26. Piece of Death (Check only one) exeminer?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To To the Hospital or Attending Physi within 24 hours after deeth.

To the Funeral Director: After this c completely filled in by the funeral dir 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signatura end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) sholl D38647 24-97 10 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

1325 MT.

Julia Sander Radal

32. Registrar's Signature

SACISBURY.

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DHMH 16 Rev 6/95

State

Registrar

4421

31. Date filed (Month, Dey, Yeer)

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A H H MAY AN X V M [

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4565 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Howard Randolph Kennedy April 11, 1997 7:25 PM 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Memorial Hospital @ Easton Easton Talbot If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Days Hours Min. January 2, 1932 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) 1MM 2□ F 217-28-2526 65 Yrs. Maryland Usuai Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits Sudlersville Queen Annes Maryland 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21668 U.S.A. 3118 Sudlersville Road 12. Wes Decedent Ever in U.S. Armed Forces? 1 23 Yes 2 □ No If Yes, Give Year or Dates: Korean Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Biack, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use refired)Supervisor 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 8 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louise Gould Emmett Kennedy 19a. Intormant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21668 3118 Sudlersville Road, Sudlersville, Maryland Marian I. Kennedy/Wife 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Pleasant Cemetery/April 19, 1997 Crumpton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Buneral Service Licenses Pellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, Maryland 21651 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or hear feiture. List only one cause on each line. Approximate Interval Between Onset end Deeth immediete Cause (Finel disease or condition resulting in death) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Physician /Medical **Examiner**

buriel-transit

The law requires that the death certificate be executed

certificate

After this

Director: /

director

Hospital or Attending Physicien: 24 hours after death.

To the

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filled within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "netural", or items 23a or 2 any injury or other traumetic event, the Medical Example 2008.

Baltimore, Maryland 21215-0020

Funeral Director

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Be Completed

the Maryland

Physician/Medical þ Completed Be 10 Certification:

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24b. Were autopsy tindinga evalleble prior to completion of cause of death? 24e. Was an autopsy performed? 12 No 1 TYes 2 No 25. Was case reterred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dinpatient 2 ER/Outpetient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the ceuse(s) and manner as stated.
 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

within 24 hours aff To the Funeral DI completely filled in

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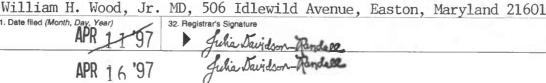
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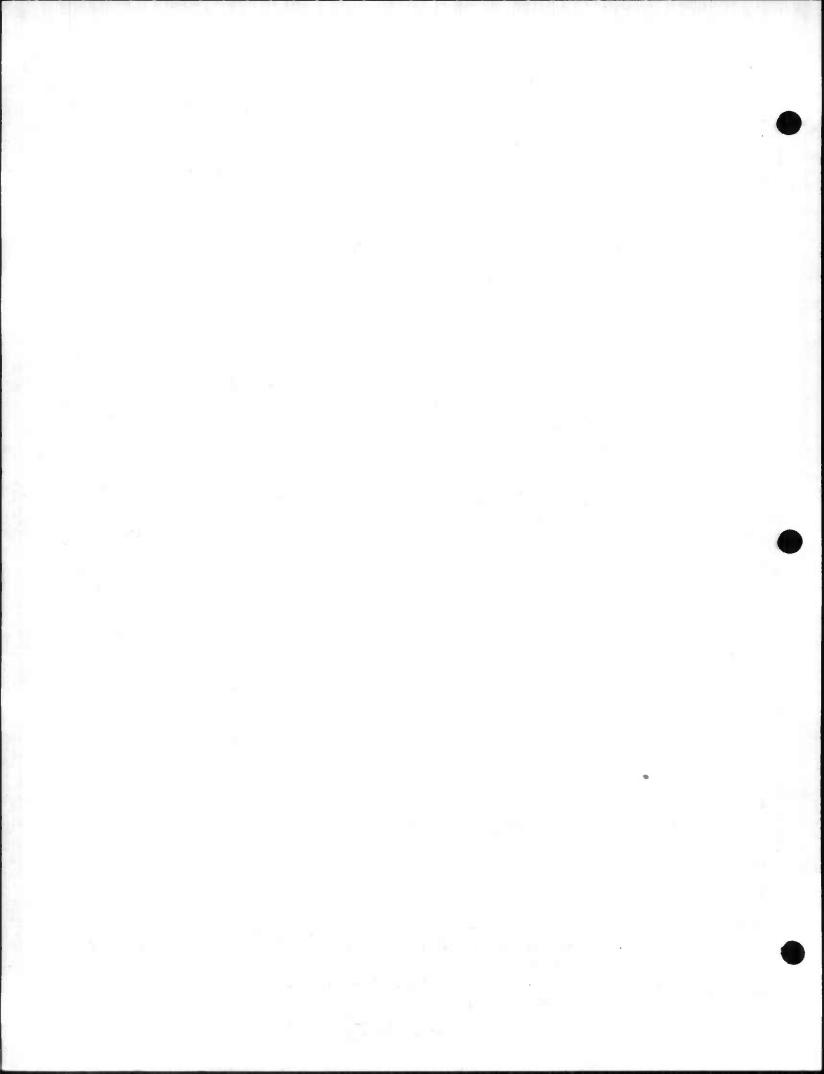
Registrar

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

30. Name end address of person who completed cause of beath (Item 23a) (Type, Print)

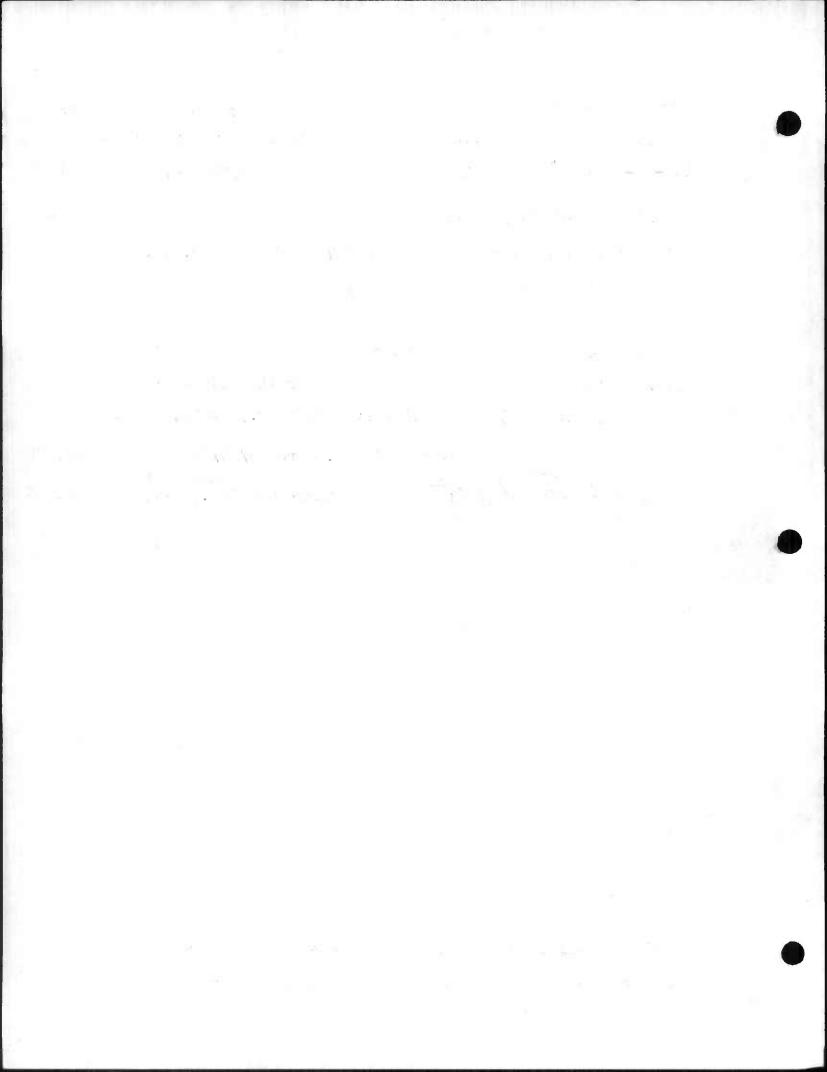




State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Yeer **Physician** Walter Kalinski 24, 1997 2030 /Medical April 4e. Facility Neme (If not institution, give straet and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Prince Frederick Calvert Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex XXM 2□ F 7. Age (In yrs. last birthday)_ 8. Date of Birth (Month, Dey, Year) APRIL 24, 9. Birthplaca (State or Foreign 1925 West VA .Funeral Days Hours 235-32-7291 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yas ZHNo Director Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? or items 23s or 20657 U.S.A. 776 White Sands Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No IYes, Give Yeer or Detes: WW II Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, atc.) Race - American Indian, Bieck, Whita, atc. 11. Maritei Status filed within 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2XXIo Spacify: by 3 Widowed 4 □ Divorced Specify: White "natural". Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Depertment of Health end Mental Hygiene Important: If flem 27 Is marked other tha any Injury or other traumatic event, that once. Grade 10 Laborer Railroad 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Carolina Blocknia Nick Kalinski 0 19a. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 776 White Sands Dr., Lusby, MD 20657 John Kalinski (son) 20b. Place of Disposition (Neme of cemetery, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Ramoval from State 4 Donetion 5 Other (Specify) 4/28/97 Middle River, MD Holly Hill Mem. Park 21. Signeture of Funeral Service Ligar 22. Name and Address of Facility Lee Funeral Home MD 20736 8125 Southern MD Blvd., Owings, 23e. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shirtk, or heert feiture. List only one cause on card line. Approximete interval Between Onset and Deeth Physician Immediete Ceuse (Finel disaase or condition resulting In deeth) /Medical Porietel Stroke 2 weeks Examiner Due to (or as a consequence of): Examiner Due to (or as e consequance of): I or Attending Physician: The law requires that the death cartificate be executed efter death.

Director: After this cartificate has been signed by the attending physician end attending physician end for use as the buriel-transit Sequentially ilst conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last P.O. Box 68760, Diebites 4 sers Physician/Medicai Due to (or es a consequence of): is certificate has been signed by the a director, page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, δ 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24a. Was en eutopsy performed? 2 0 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Menner of Deeth 28e. Date of injury (Month, Dey Yaar) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Division** 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital n 24 hours on Funeral 1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, date and plece, and due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the ceuse(s) Medical 29a. Certifiar To the within 2 To the end menner stated. 29b. Signature end title of certifier 29c. Licansa number 29d. Date signed (Month, Dev. Year) B 38991 25. 1997 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 10+1 DIPRE 130 MOSPITAL ROAD PRINCE MILWAEL FREDERICK an 32. Registrar's Signature 31. Dete filed (Month, Dey, Yeer) State APR 28 Registrar

DHMH 16 Rev 6/95

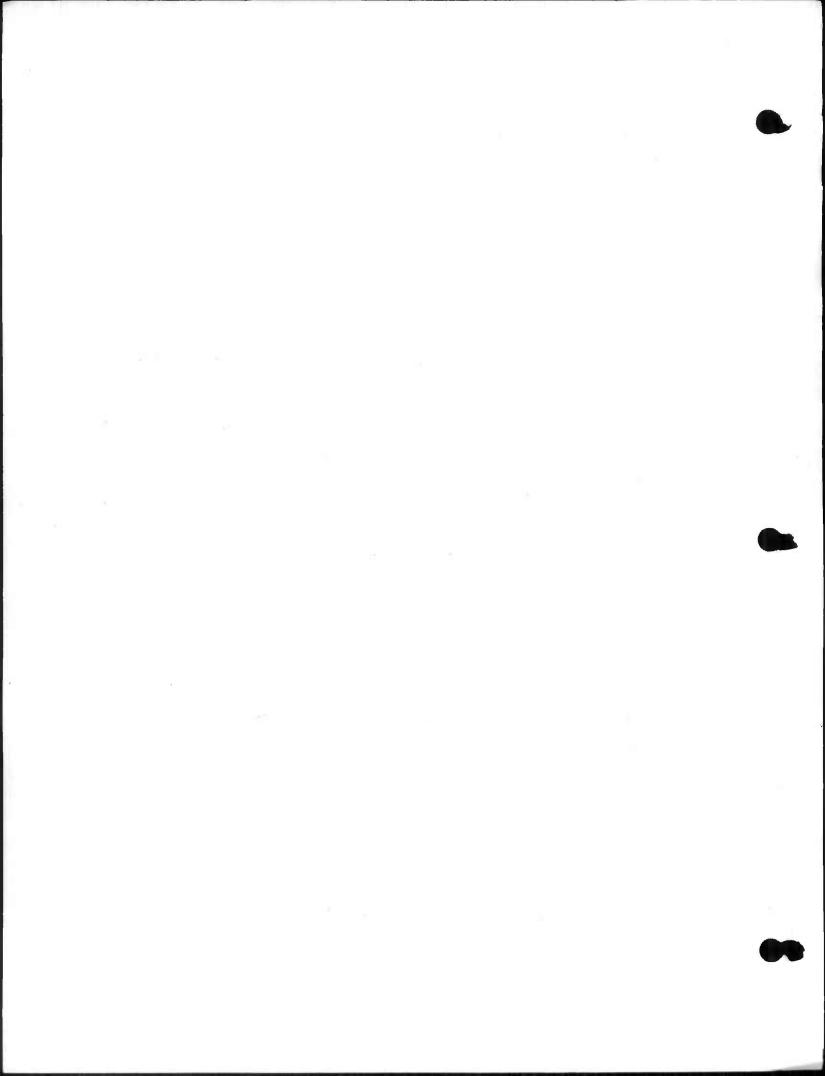


Amended #2, Mas, 5/5/97, Allegany County

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

			REGISTRAN			CENTIF	ICAIL	Ol	DEA	ın		REG. NO.			
			1. DECEDENT'S NAME (First, Middle, Last)							2. DATE (OF OEATH	w 1997	luras.	3. TIME OF DEATH
			KATHRYN REBECO	CA KERNS							MAY	1	1077	YEAR	4:18 AM M
_			4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In y	rrs. last birthday)	IF UNDER 1	YEAR	IF UNDER	24 HRS.	7. DATE C	F BIRTH	17/7	a. BIRTHE	PLACE (State or Foreign
			224 26 6205	1 🗆 M 2 🗔 F		YRS.	MONTHS	DAYS	HOURS	MIN.		Day, Year)		Country	
	phoods		234-36-6295 98. FACILITY NAME (If not institution, give	etmet and number	88_		at CITY	70404	OR LOCATIO			20 1			W.VA.
	S Sh	ایرا					9b. CITT,	TOWN C	DH LOCATI	UN OF DE	EATH		9c. COUN	ITY OF OE	ATH
	ς,	일	ALLEGANY CO. NURS	ING HOME			CUMB	ERL.	AUD				ALI	EGAN	Y
	SS.	DIRECTOR	10e. STATE 10b. COUN			10c CIT	Y, TOWN OF	R I OCAT	TION		-				10d. INSIDE CITY
	Pag.	[뜻]	WARTE AND				1000							- 1	LIMITS?
	permit. Pages		MARYLAND ALI 100. STREET AND NUMBER	EGANY		C1	UMBER		_						YES 2 NO
		FUNERAL	106. STREET AND NUMBER					101	. ZIP CODI	E			10g. CITIZ	ZEN OF W	HAT COUNTRY?
	physician. burial-transit	導	502 MARYLAND A	VENUE					2150)2			II.S	Α.	
0	Sicia ial-tu	5	11. MARITAL STATUS	12. WAS OECEDEN FORCES? 1			13. W	AS DEC	ENDENT O	F HISPAN	IIC ORIGIN?	(Specify Yea	or No-	14. RACE	- American Indian, White, etc.
00	Par Da		1 Never Married 2 Married	IF YES, GIVE V	MAR OR DATE	s X			2 NO		n, Puerto Ri	can, stc.)			
5-0020	as the	ВУ	3 Widowed 4 Divorced	<u> </u>					Y_						WHITE
21	r atter	ETED	15. DECEDENT'S ED (Specify only highest gra-		18	Give kind of	USUAL OC	CUPATIO	ON		16b.	KIND OF BUS	SINESS/IND	USTRY	
21	the hospital or attending physician, detached for use as the burial-tran once.	Lij	Elementary/Secondary (0-12)	College (1-4 or 5	+)	life. Do NOT us	se retired.)	aring mo	SI OF WORKE	y					
0	Spitt hed	I de	8			HOUSE F	ZEEDE.	D				HOUSE	KEEP	ER	
AND	the hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	HER'S NA		iddle, Maiden		DIC	
7	# E E	m o	HARVEY PROUDFOO	т					l .		APHIS				
C C	retained 5 should notified	00	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	AOORESS	(Street a				c City or Town	n Ctote 7in	Codel	
MA		임	JAMES PETERS	NEPH	7 171 7										
யி	ay be		20a. METHOD OF DISPOSITION	NEPF		P.O.BO				APT					
S.	e 6 may be ector, page must be		1X Burlel 2 Cremetion 3 Re	moval from State	cemeter	ry, crematory or o	ther place)				OATE		CATION — C		- II
ž	direc		4 Donation 5 Other (Specify)	Annual Manager	<u> </u>	DROW CH						RFD	PAW	PAW	W.VA.
LTIMO	nin eral		21. SIGNATORE OF FUNERAL SERVICE I	INI SI	1				O AODRES			DAT II	21/17		
AL	after death. Page 6 m by the funeral director, moval.	l ii:	Dala Z	March								RAL HO			
00	rs after by the removal		23. PART i. Enter the diseeses, or	complications the	of coursed th	ne deeth. Do	1404	4 DI	LCATU	JR S	REEL	CUMB	ERLAN	D MA	RYLAND
_			shock, or heart tailure	. List only one ceu	use Dn eech	line.	not onter t	THE THIC	de or dyr	ng, auci	n aa cardi	ac or reap	ratory arri	pat,	Approximate Interval Between
	filled on or he m	- 1	iMMEDIATE CAUSE (Finel disease or condition												Onset and Death
Ţ	ompletely fille d, cremation, event, the		resulting in death)	e. CORDI	UALLY	AR	SEV	4	1015	874	-SE				2 YRS
160	completely ial, cremati			OUE TO	(OR AS A CO	ONSEQUENCE O	F):	,	, , , ,						
68760,		Z	Sequentielly list conditions.	b											
XO	h certificate be executionally and compared by Hygiene prior to buriful or other traumatic	ERTIFICATION	it any, leading to immediate	OUE TO	(OR AS A CO	ONSEQUENCE O	F):								
BO	ysician prior 1	S	cause. Enter UNDERLYING CAUSE (Disease or Injury	C											
0	certificate ding physi lygiene pr r other t	E	thet initieted events	DUE TO	(OR AS A CO	ONSEQUENCE O	F):								
Р.	he death certificate be to the attending physician Mental Hygiene prior to Ijury, or other traun	E	resulting in death) LAST	d.											
Ś	death e atten lental P	O													
0	5 - 5	EDICAL	PART II. Other significent condition									24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
OR	signed by Health and Ws any	8	CAREINOMA	- OF	THE	LUNG	7					1 YES 2	1		COMPLETION OF CAUSE DF DEATH?
C	uires th signed Health DWS an												• 2		_ //
R	been t. of sho	Σ.	DID TOBACCO USE	CONTRIBUT	E TO C	AUSE OF	F DEAT	H Y	/ES [1 NC					1 YES 2 NO
AL	SICIAN: The law require certificate has been shift the State Dept. of H d, or item 23 shoy	SICIAN:	25. WAS CASE REFERRED TO MEDICAL					_			eck only one				
VITAL	Cate State	<u> </u>	EXAMINER?	HOSPITAL:	1		OTHER								
>	o the	₹	27. MANNER OF DEATH	1 Inpatient 2						sidence	6 Other				
OF	PHYSICIAN: The law requirities certificate has been with the State Dept. of Irked, or item 23 sho	PHY	1 Matural 5 Pending	28a. DATE OF (Month, D	ay, Year)	28b. TIM	JURY	28c. INJI WO	URY AT RK?		28d. DE\$0	RIBE HOW II	NJURY OCC	URED	
Z		BY	2 Accident Investigation				М		rES 2	NO NO					
DIVISION	O A D M		3 Suicide 6 Could not be	28a. PLACE C building,	OF INJURY — atc. (Specify)	At home, farm,	atreet, factor	ry, office			261. LOCA	TION (Street a	ind Number	or Rurel Ro	oute Number,
VIS	DIRECTOR: hours after item 28 i	=	4 Homicide determined								ony o	ioviii, Giaidy			
0		COMPLE	29a. CERTIFIER (Check only	SICIAN: To the best of	my knowlede	na, death occurr	nd at the tim	ne dete	and place	and due	to the caus	o(a) and man		4	
	RAL SE	Σ	one) 2 MEDICAL EXAMI												
	HOSPITAL FUNERAL WITHIN 72 TANT: II	8					л, ш шу ор		watti occur		time, date e	ma piaca, am	d dua to the	cause(a)	and manner as stated,
	TO THE HOSPITA TO THE FUNERAL DE filed within 72	8	296. SIGNATURE AND TIPLE OF CERTIFI						29c. LICE	NSE NUM	IBER		29d. DATE	SIGNEO	Month, Day, Year)
	M P d d	0		tomen					D	1486	5		M	44	1, 1997
1	TO THE FUNERAL TO THE FUNERAL De filed within 72 IMPORTANT: II	- 1	30. NAME AND ADDRESS OF PERSON W												
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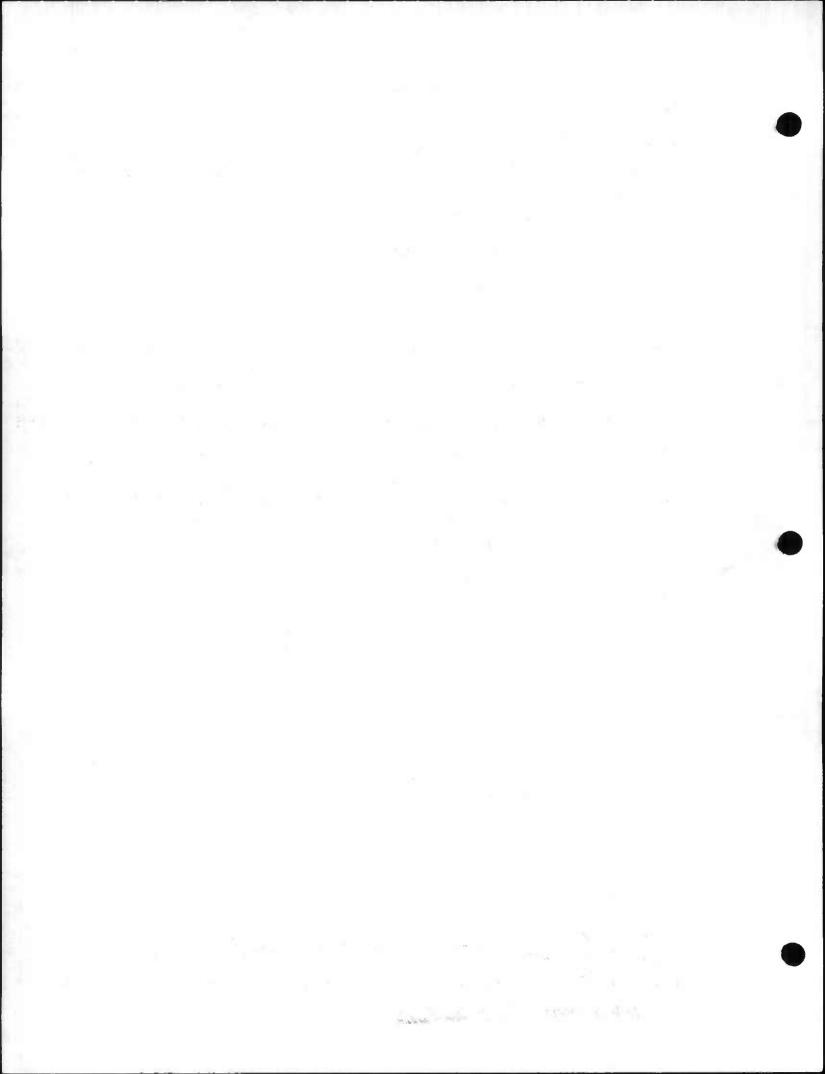


State of Maryland / Department of Health and Mental Hygiene

97

				Cer	tificate of	Death		Reg. No.	- 1	14000
		1. Decedent's Nama (First, Middla, L	ast)				2. Data of De	eath	and a	3. Time of Death
Phys		Tuthon	. 1 1	77			May 3	1997 Day	Yaar	12:31PM
7	dical	Luther 4a. Facility Nama (If not institution, g	illen	Korns		4h City Town (or Location of Dear		of Dooth	12.51111
ا (Exan	niner	The Second Parish Selling Second	The second second second			4b. Oky, 10mi, 0	or Ecoation of Dea	40. County	OI Death	
		11219 Hillside				Midlo	thian	A1	legany	7
Funer	al			a (In yrs. last birthday)	If Under 1 Year Months Days	Hours M	rs. 8. Data of Bi	rth ay, Year)	9. Birthple	roa (Stata or Foraign y)
Directo	or	208 26 4957	X □M 2□F 68	Yrs.				7, 1929	PENNS	YLVANIA
2		Usual Rasidance of Dacedant		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
yler How		10a. Stata 10b. County		10c. City, Town or Loc	cation				100	d. Insida City Limits
M I	Ş	MD ALLEGA	ANY	FROSTBI	URG					1 ☐ Yas 2 🕱 No
the root	Director	10e. Straet and Number			10f. Zip Code			10g. Citizen of V	What Countr	ν?
Wild Wild					0.15	• •				
21215-0020 d within 72 hours after deeth with the Maryland piene. r than "naturel", or frems 23s or 28s-f show the Medical Examiner must be notified at	Funeral	11219 HILLSIDE DE		Francis II C 40 W	215		/C===16 - V== == N	U.S.		n Indian
ar de	Š	11. Marital Status	12. Was Dacedant Armed Forcas?	let let	Yas Decedant of P Yas, specify Cub	an, Maxican, Pu	(Specify Yas or N arto Rican, atc.)		e - Amarica: ck, Whita, at	
So aft		1 Navar Married 2 Married		No 2/23/51	☐ Yas 21 No	Specify:		Specifi	WHIT	F
on in	À	34 Widowed 4 □ Divorced	Yaar or Datas:2	2/25/53	Λ.			0,000,0	· WIIII	. •
72 h	Completed	15. Decedant's I (Specify only highast g	Education rada completed)	16a. Deced	ant's Usual Occup	oation	vadrina	16b. Kind of Bu	usinass/Indu	stry
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Z Wind	5	3		LA	BORER			CONS	TRUCTI	ION
nd 2	Be	17. Fathar's Nama (First, Middla, Las	it)			18. Mother's N	lama (First, Middle	e, Maidan Suman	na)	
Mark Mark	TO B	ALLEN LESTER K	ORNS			GLAD	YS EDNA	BITTNER		
arylan should be and Mentel merked of	-	19a. Informant's Name/Ralationship		19h Mailin	a Address (Street		Rural Routa Numl		State 7in (Code)
6 4 4 4 6		VALERIE KORNS/PA		GHTER 11219						
1 and 1 and Heelth em 27			LITER DAU			DKIVE				
Baltimore, Semit. Peges 1 at Department of Hee mportant: If them any injury or othe		20a. Method of Disposition 1⊕ Burlal 2 ☐ Cramation 3	Ramoval from State	20b. Placa of Dispos camatary, cram	natory or othar pla	ce)	Data	20c. Location -	City or Tow	n, Stata
Peges nent of h		4 □ Donation 5 □ Other (Spec		ROCKY GAP	VETERAN	IS CEM	5/5/97	FLINTST	ONE,	MD
Baltimore, N permit. Peges 1 and Department of Heelth Important: If New 27 any Injury or other to	.	21. Signature of Funeral Service Lice	ensee /	22.	Nama and Addra	ss of Facility				
n ages	Suce	Mhile	TNV							
_		220 Part Fater Marchey	111100				ROSTBURG			A
		23a. Parl1. Enter the disease, or conshock, or heart failure. List only	y ona causa on aach iii	na.	ar tria moda or dyi	ng, such as card	nac or raspiratory	arrast,		Approximata IntarvsI Between
Physicial	_								1	Onset and Death
/Medica Examine	-	Immediata Causa (Final disaasa or condition	Ischem	ic myocardo	pathy				u	k yrs
LXaiiiiie		rasulting in death)	Diabak	Dua to (or as a consequES	uence of):					
D #	<u> </u>		Diabet	es					u	k yrs
X 68 / 60, entificate be executed sing physician and se es the buriel-transit	Examiner	Sequentially list conditions	b	Dua to (or as a consequ	uance of):				1	
D, exe mar ar rief-t	X	Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying							į	
barbu, ficate be ex g physician es the buriel	edical	Causa (Disaasa or Injury thet Initiated evants	C	Dua to (or as a consequ	ience of).					
ficat pp.	8	rasulting in daath) Last		Dua to (or as a consequ	Janica Orj.					
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DO Deth of Do Do Do Do Do Do Do Do Do Do Do Do Do	Physician									
requires that the death seen signed by the etter hould be deteched for u	Si	Part II. Other significant conditions	contributing to death be	ut not resulting In the un	darlying causa gh	ven in Part I.	23b. Did	tobacco use co	ntribute to I	the cause of death?
T to Determine the property of	윤	}					1	Yes 2 No	3 Probe	bly Unknown
S, T	P						_			
quin quin uld								s an autopsy ormed?		e autopsy findings lable prior to
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The lew requires the lew requires the less been signed page 2 should be on the less bear signed be on the less bear signed be on the less bear signed	Completed							~		
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ysician: Thy ysician: The is certificate director, pag	BB	25. Was casa rafarred to medical examinar?					Death (Check only	ona)		
- 5 00	2	Yas 2□ No	Hospital: 1 Inpatia	nt 2 ER/Outpatient	t 3□ DOA Ott	nar: 4 Nursing	Homa Ras	idanca 6 Oth	ar (Specify)	
OIVISION OI or Attending Physafter death. Director: After this in by the funeral d	Ë	27. Mennar of Death	28a. Data of Inju (Month, Da)	ry 28b. Tima of Injury	28c. Inju	ry at	28d. Describe	how injury occur	red	
VISION Attending Ir death. ector: Afte by the fune	atic	1 Natural 5 Panding 2 Accident Invastigation		,		Yes 2 □ No				
Afte Profession of the Color of	을	3 Suicida 6 Could not detarminad	Zoa. Place of Inju	ury - At homa, farm, stra	at, factory, offica			(Street and Numb	per or Rural	Routa Number,
dig de la	Certification:	Homicida	building, afe	c. (Spacify)			CRY OF TO	wn, State)		
UNISION Hospital or Attending 24 hours after death. Funeral Director: After telly filled in by the fune		29a. Cartifiar 1 Certifying P	hvalcisn: To the best of	of my knowladga, daath	occurred at the til	ma, date and pia	ica, and dua to the	causa(s) and ma	annar as sta	ted.
Ho 24 h Fur ately	edical	(Check only one) Medical Exa	miner: On the basis of	examinetion and/or inv	astigation, in my	pinion, death oc	curred at tha tima	data and pieca,	and dua to t	he cause(s)
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th complately filled in by the funeral	M	29b. Signatura and titla of confiler	7		29c. Licens	a number		29d. Data signe	d (Month D	lav. Year)
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4		1 touch	~	Dpty Med	ex D 0	9157		May 3	1997	
41		30. Name and appress of person who	complated cause of d	eeth (Item 23a) (Type, F	Print)					
1000		Paul Snow M	.D. 124 w	3rd of Com	h MA 215	0.2				
S	tate	31. Data filed (Month, Day, Year)	- 31 Regist	3rd st Cum	v riu 215 I	VZ				
Regis		MAY 05 K	197 Julia	made a middle	V					

					Marylar		artment of rtificate o	Health and f Death	Mental Hy	/giene Reg. No.	97 14569
	Physic /Medi	cai	1. Dacedent's Nama (First, Middle, L TUEMA L.	Ken.	SHNER	Louise	e Kershn		2. Data of D Month	Day 2	Year 7997 2047
	Funeral Director	ner	4a. Facility Name (If not Institution, g NIVERS (TY 0/- M/A) 5. Social Security Numbar 218-38-1007	LYCANO NO			T	BALTIMO ar If Undar 24 Hr	r Location of Dea	Balti	
	D .		Usual Residence of Decedent 10a. State 10b. County			ity, Town or Lo					10d. Inside City Limits
	with the Mi 3a or 28a-f	Funeral Directo	Maryland Washin 10e. Street and Number Milestone Garden			liamspo pt- 2-F	10f. Zip Code			10g. Citizen of U.S.A.	
020	s 1 and 2 should be filed within 72 hours efter death with the Manyland female and Mentel Hygiene. 14 Health and Mentel Hygiene. 15 In marked other than "natural", or frems 23a or 28a-f show other traumatic evant, the Medical Evanthet must be nullined at	by Funera	11. Marital Status 1 □ Never Married 2 □ Married 3 🐕 Widowed 4 □ Divorced	12. Was Deca Armed For 1 Yes If Yes, Giv Yaar or De	2∯No e		Was Decedent of If Yas, specify Co	f Hispanic Origin? (uban, Maxican, Pue o <i>Specify</i> :	(Specify Yes or N erto Rican, atc.)		ca - American Indian, ck, White, etc.
21215-0020	filed within 72 hou Hygiene. ther than "natura int, in Medical	Completed	15. Decedent's Elementary/Secondary (0-12) 7 Years	ducation		16a. Deced (Give life. I		supation ne during most of w red)	orking		usiness/Industry
70	should be filed with nd Mentel Hygiene. marked other than imatic event, the	To Be Co	17. Father's Name (First, Middle, Las Walter Lloyd Tru			110111031			ame (First, Middle	, Maiden Suman	
ore,			19e. Informant's Name/Reletionship Geraldine Beard / 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3	Daughte	20b. F	Miles Place of Dispo	stone Ga sition (Neme of matory or other p	iace)	Apt-2-	B Willia 20c. Location	msport, Md. 2179
Baltimore,	permit. Page Department of Important: If any Injury or once.		4 Donetion 5 Other (Spec	Fin		22 I 13	oo Last	lress of Facility A. Fiery ern Blvd.	Funeral N. Hage	Home erstown,	erstown, Maryland Maryland 21742
Α.	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final diseasa or condition rasulting in death)		/			ying, such as cardle			Approximate Interval Between Onset and Deeth
58760,	icete be axecuted physician and s the bunel-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events	b. Se	Due to (c	or as a conseq	uenca'of): MAUG	NAWCY			Harain.
	ath certif	Physician/Medi	rasulting In death) Last	d		r as a conseq					i i
7. O	es thet the gned by th be detache	by	Part II. Other significant conditions Conowary A	contributing to de		ulting In the un	nderlying cause	given in Pert f.		Yee 2 No	ntribute to the cause of death? 3 Probably 4 Unknown
9	has been ge 2 shouk	Completed	Mypercuneste Pormera Vasas			AS ETES	Merce	NS	perfe	an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?
of Vital	ysician: is certific director,	To Be	25. Was case referred to medical exeminer? 1 Yes 2 No 27. Manper of Death	Hospital:	patient 2	ER/Outpatian	T JL DOA	thar: 4 Nursing	eath (Check only Homa 5 Res	dence 6 Oth	
vision	leeth. lor: After the fune	Certification:	1 Naturel 5 Pending investigation 3 Suicide 6 Could not be determined.	n 28a. Place	, Day Year)	28b. Time of Injury	M 1[☐ Yas 2 ☐ No	28f. Location (how Injury occur Street and Numb	red ber or Rural Route Number,
2	within 24 hours effer of To the Funeral Direct completely filled in by	edicai Cer	29e. Certifier 100 Certifying Pt	yalcfan: To the t	est of my kno	wiedne death	occurred at the estigation, in my	time, dete and piac opinion, death occ	e and due to the	causa(s) and me	anner as stated. end due to the cause(s)
)	within To th comp	Me	29b. Signature and title of certifier	Jaum	<i>p</i>		AU4170	nse number 6 435 ASZ	134	1	d (Month, Day, Year) 2 4/997
	Sta Registra		31. Dete filed (Month, Day, Year)		of death (Item 19 DVI) gistrar's Signa	SIAN OF	CT SUR	sery, LZ	S. GREEN	EST BA	nn. Mo 21201

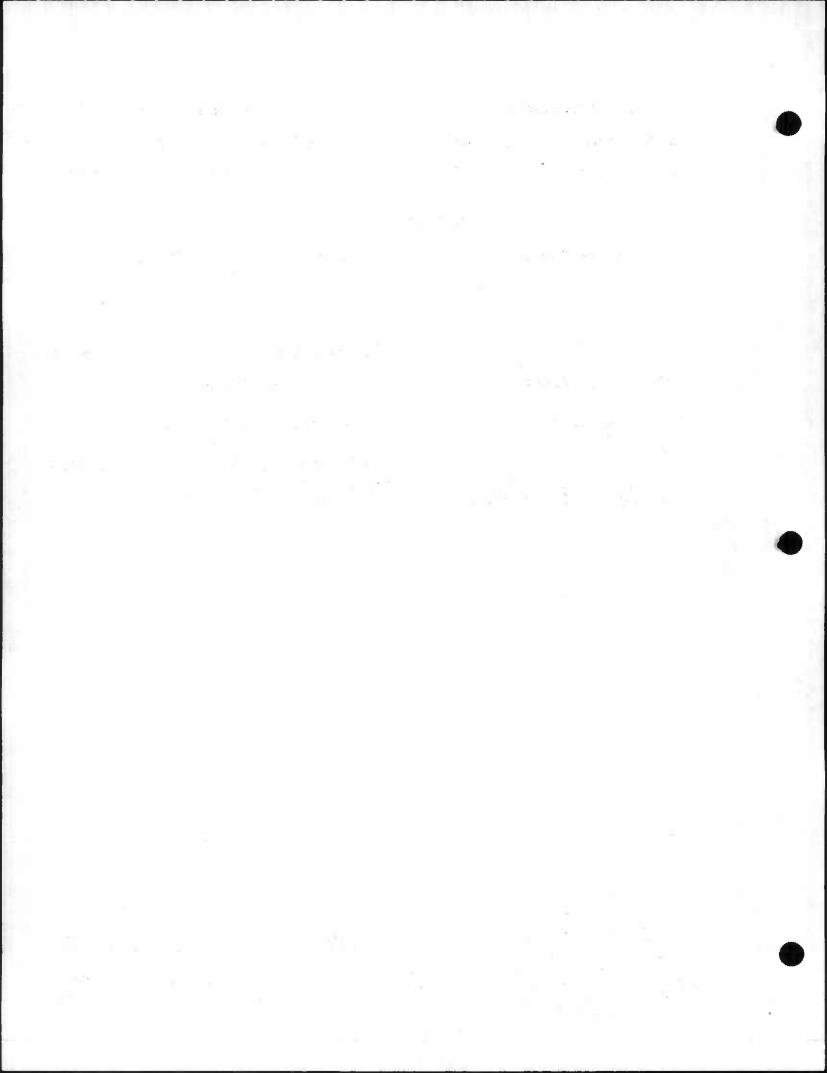


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					Cer	tificate o		. Workar Fr	Reg. No.		45/0		
Physic	clan	1. Decedent's Neme (First, Middle		2. Date of Death Month Day Year 3. Time of Death									
/Med		Herbert Harrison Lantz						4 4 4	11, 199	7 (2:30 p.1		
Exam	iner	4e. Facility Name (If not institution	The state of the s	*			4b. City, Town, or Location of Death 4c. County of Death						
		163 Sassafras S			lest birthday)		Millin						
Funera Directo	_	5. Social Security Number 218-01-2505 Usual Residence of Decedent	If Under 1 Yes Months Day		tf Under 24 Hrs. s. Date of Birth (Month, Dey, Year) 9. Birthplace (Stete or Foreign Country) October 15, 1914 Maryland								
		10a. State 10b. County		10c. Ci	ty, Town or Loc	ation				10d	Inside City Limits		
he Mary 8a-1 sh	Funeral Director	Maryland Kent Millington								1 ☐ Yes 2 No			
vith t	Oir	10e. Street and Number 10f. Zip Code 10g. Citizen of What (
s 23	era era	163 Sassafras S	12. Was Deceden		10 100	216			U.S.A				
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Manyland th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Mental Event net mail be notified at	þ	1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yes 2 ☑ 1 ☐ Yes 2 ☑ 1 ☐ Yes 2 ☑ 1 ☐ Yes 2 ☑ 1 ☐ Yes 2 ☑ 1 ☐ Yes 2 ☐ 1 ☐ Yes 3 ☐		? No	- It	/as Decedent of Yes, specify Cu ☐ Yes 2 12 No	i Hispanic Origin? Iban, Mexican, Pue o Specify:	(Specify Yes or N arto Rican, etc.)	14. Race - American Indien, Black, White, etc. Specify: White				
5-C	Completed	15. Decedent' (Specify only highest	s Education grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of world; ife. DO NOT use retired)			rorkina	16b. Kind of B	Kind of Business/Industry			
within ene.	dE	Elementery/Secondary (0-12)	College (1-4or	5+)									
d 2 filed v filed v filed v	ပိ	7	2241		TOOL S	tore Su	pervisor				nufacture		
S and S	Be	17. Father's Name (First, Middle, Lest) William Godfrey Lantz						ame (First, Middle, Meiden Sumeme)					
arylan should be f ind Mental I merked of umeric eve	2				401-14-14				Wherrette				
md 2 sho alth and 27 is m		19e. Informent's Name/Reletionsh Edith B. Lantz/						or Rurel Route Number, City or Town, Stete, Zip Code)					
ore, Marylc ss t and 2 should of Health and Mer frem 27 is marke other traumatic		20a. Method of Disposition	wite	20b. F	Place of Dispos	BOX L,	Milling	con, Mar		.651 - City or Town,	State		
altimore, mit. Pages t ar partment of Heal portant: if Item 2 y injury or other		₩Burial 2 □ Cremation		,	camerery, crem	etory or other p	,						
Baltimo permit. Pages Department of Important: If I any injury or		21. Signeture of General Servica L	4 Donation 5 Other (Specify) Asbury Cemetery/April 14, 1997 Millington, Maryland 21. Signeture of Meral Servica Licansee										
B Per Per Per Per Per Per Per Per Per Per		Fellows, Helfenbein & Newnam Funeral Home P.A											
		23a. Part 1. Enter the disease, or c shock, or head allure. List of	omplications that cause	d the deat	370) West	Cypress	Street,	Milling	ton, M	aryland		
Ohyalalan		shock, or heart allure. List of	niy one cause on each l	line.	ii. Do not ente	i the mode of dy	ying, such as cardi	ac or respiratory i	arrest,	Intr	erval Between 51		
Physician /Medical	ш	Immediate Cause (Final	(0		P	0				2	1		
Examiner		disease or condition resulting in deeth)	e. Clar	مف	1	em	7			-	yrs		
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bette by	Examine	Sequentially list conditions	b. —	Due to /c	or as a consequ	ence of):					1		
day day		Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseasa or Injury		D08 (0 /c	n as a consequ	s a consequence on).							
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S the state of the	Med	resulting in deeth) Last											
S 8 9 8	an/N		d										
* 6 e 5	sici	Part II. Other significant condition	s contributing to death t	out not res	ulting In tha und	derlying cause g	iven in Part I.	23b. Did	tobacco use co	entributa to the	cause of death?		
That the detact detact	by Physician/I	COPD-						×	Yes 2 No 3 Probably 4 Unknown				
0 8 40								24e. Wes	an autopsy	24b. Were a	autopsy findings		
0 2 0 11	Completed							. pen	ormed?	comple	ole prior to etion of causa th?		
The lay	E							1□	Yes 20 No	1 □ Ye	~		
VICES I	Be	25. Wes case reterred to medical					26. Place of De	eeth (Check only	/\				
m & m 10	10	examiner? 1 ☐ Yes No	Hospital: 1 ☐ Inpati	ent 2	ER/Outpatient	3□ DOA O	Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
	222	27 Manner of Deeth Netural 5 □ Pending	28a. Dete of Inju (Month, De	iry V Year)	28b. Time of Injury	28c. Inj		7	how Injury occur	red			
Attending at death. sector: Alter by the fune	cati	2 Accident Investiga		Yes 2 □ No									
5 5485	Certification:	3 Suicide 4 Homicide 4 Remined 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify)					City or Town, State)						
e Hospital 24 hours e Funeral letaly filled	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, and due to the ceuse(s) and manner es steted. (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date on the ceuse(s) and manner es steted. (Check only one)											
To the To the	₩.										Year)		
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	0	70. Name and eddress of person w	no complete cause of	leath (Item	23e) (Type. P	rint)	1	0:	14	1/1	.60		
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APR 16'97 Julia Davidson-Randelle

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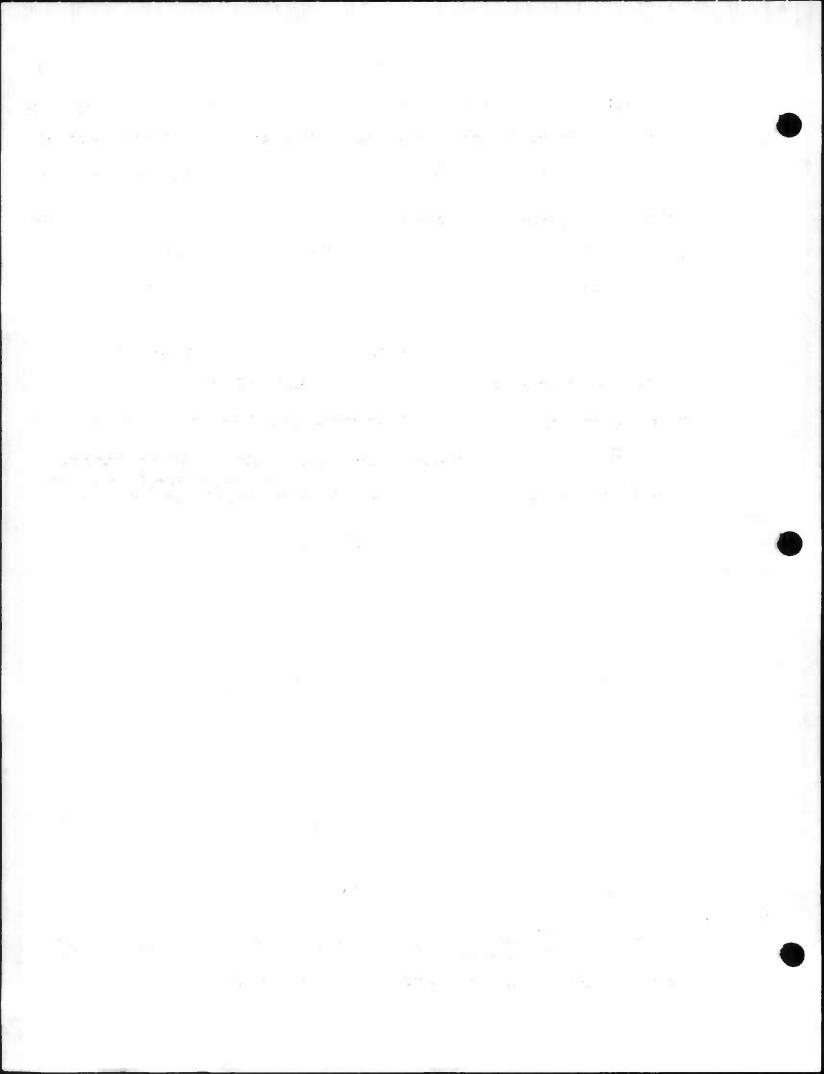
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedant's Nama (First Middle Last) 2. Deta of Death **Physician** April 23, Charles Willard Lowe, Jr. 19 9 7 11:06 AM /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hosptial Center Clinton Prince George's If Under 1 Year If Undar 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F 71 579 26 4381 Yrs Director March 18, 1926 Wash, DC Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours effer death with the Maryland nent of Health and Mental Hyglene. nt: If Ifem 27 is marked other then "natural", or items 23s or 28s-f show 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Maryland Director 1 Yes 2 No Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8010 Colonial Lane 20735 United States by Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ≧Yas 2 □ No If Yes, Give Year or Dates: 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Bleck, White, atc. 1 Never Married 2 Married 21215-0020 1 Tas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Andrews AFB Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maidan Surname) Be Charles Willard Lowe, Sr. Mabel Leola King 19a. informent's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: if item 27 is any Injury or other trai 1675 Sandgates Road, Mechanicsville, Md 20659 Mary Margaret Lowe 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 24, 1997 Clinton, Maryland Lee Crematory 21. Signature of Funerel Servica Licensa 22. Nama and Address of Fecility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735 23a. Part1. Entar the disease, or complications that caused the death. Do not anter tha moda of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Finei disaese or condition resulting in deeth) /Medical Examiner Due to (or es a consequence of) Examiner homon or Attending Physician: The law requires that the death certificeta be associled after death. ettending physician and for use as the bunal-trensit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by t 1 ☐ Yee 2 ☐ No 3☑Probably 4☐Unknown by 24b. Wara autopsy findings evallabla prior to completion of cause of deeth? Completed 24a. Was an autopsy has e 2 certificate 1 Yas 20 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 2 Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yea 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Menner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation Naturel 1 ☐ Yes 2 Accident Director: in by the 3 Sulcide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, farm, street, factory, office building, stc. (Specify) 4 | Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 12 Cartifying Phyeician: To the best of my knowledge, death occurred at the time, date end pieca, and due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) and menner stated. 29b. Signature end into of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) ace 30. Name end eddress of person who completed cause of death (Itam 23e) (Type, Print) Rene Grace, MD 9131 Piscataway Road, Clinton, Maryland 20735 31. Data filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

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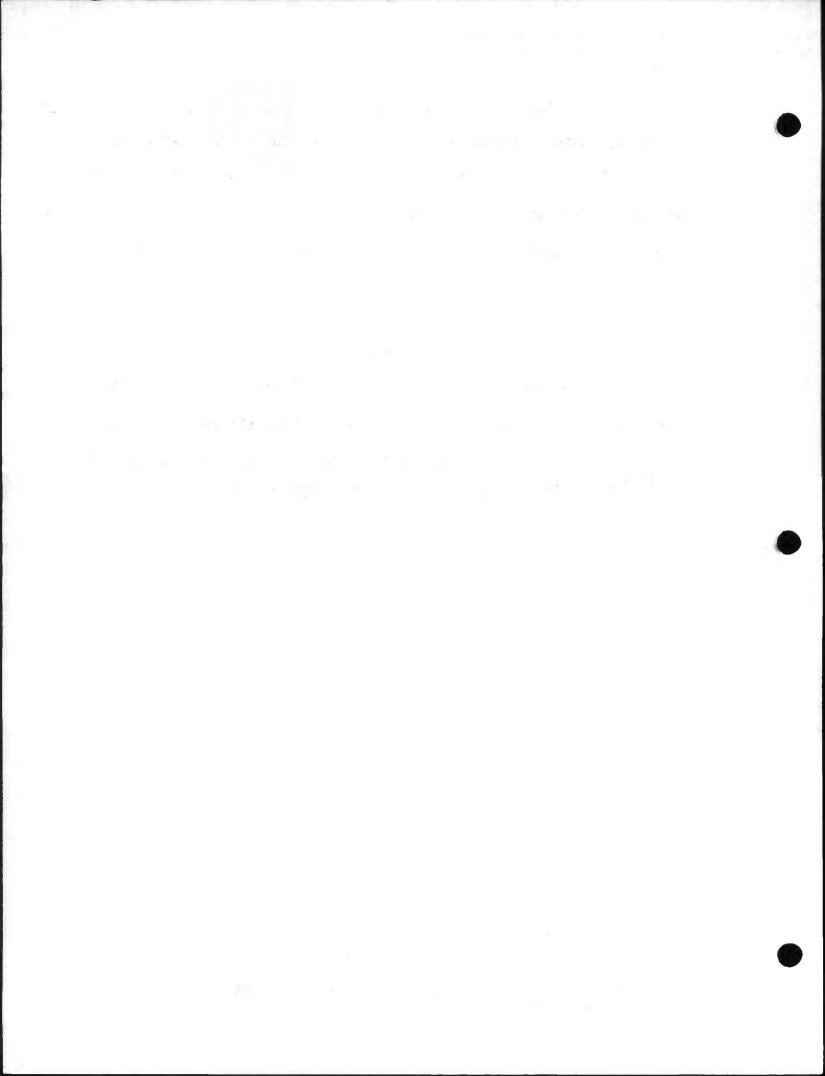
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e, Marylan 1 and 2 should be	ahow 1 at	_	10a. Stete 10b. County Maryland Wicomic	20		y,Town orLo Salisbu								10d. Inside City Limits	
	W F	Director	Maryland Wicomico Salisbury									1 Yes 21 No			
	vith th	Dire	10e. Street and Number 10f. Zip Code 21804							10	g. Citizen of V	Vhat Cou	ntry?		
	ath v	Funeral	3382 Pocomoke Road 21804 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispenic Origin?												
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	s 1 and 2 should be filed. I Haalth and Mental Hyg. tem 27 Is marked othe other traumatic event,		19e. Informent's Neme/Reletionship (Typ								alisbury		wn, Stete, Zip Code)		
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saltimore,	교본관금		21. Signature of Aumeral Service Licensee MO/051 22. Name end Addrass of Facility												
ñ	Depa Impo		Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804												
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WILLIAM ROBINS, M.D. 1104 HEATHWAY DR., SALISBURY, MD. 21804
31. Dete filed (Month, Day, Yeer)
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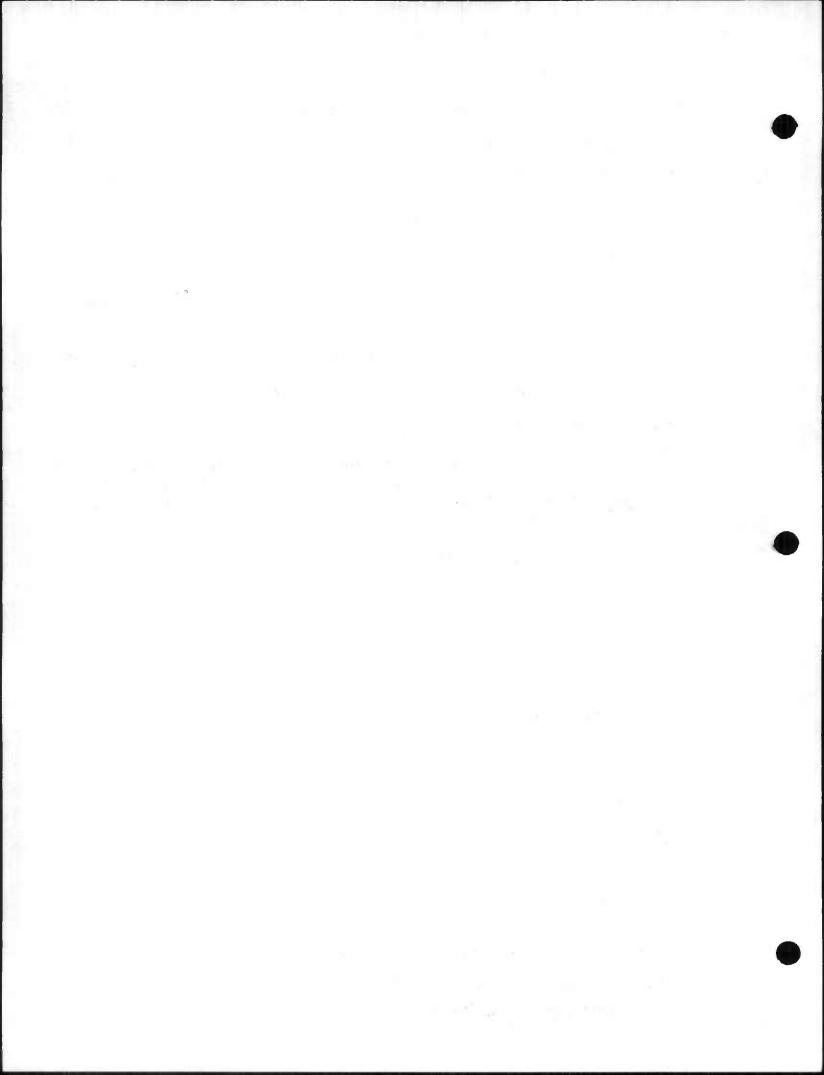
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State Registrar



State of Maryland / Department of Health and Mental Hygiene 9 7

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	To the Hospital or Attending Physician: within 24 hours side deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Σ	29b. Signeture end	title of certifier					290	. Licens	e number			29d. Dete signe	ed (Month,	Dey, Year)	
	->-0	8	1Xn	2X.	0				Ω	E	in	CC		ipul.			
			30. Name end eddr	ess of person who	completed car	se of death	(Item 23e)	(Type E	Print)	16.				Mo we	~)		
			Karl	PKIL		Tow			R	41.	1000	R=	M.D.				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14574 Cartificate of Death 1. Decedent's Name (First, Middle, Lest, 2. Dete of Deeth 3. Time of Deeth **Physician** APRIL ainia 14:25 /Medical 4e. Fecility Neme (If not institution, gi 4b. City, Town, or Location of Death **Examiner** 4c. County of Deeth MANJand Hospital Shock Traumal Boutinore

Tang (In virs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Month University of If Under 1 Yeer Months Deys 5. Social Security Number "Funeral 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) 1 ☐ M 2 🛛 F Hours 217-05-3155 80 Director Oct. 17, 1916 North Carolina Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits event, the Medical Examiner must be notified at Maryland Harford Director Bel Air 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1314 Conowingo Rd. 21014 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Importment: If if ten 27 is marked other than "natural; or items 23s my Injury or other traumatic event, in Medical Essan ten must Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 ₩Widowed 4 Divorced Specify: White Yeer or Detes: Completed 16e. Decadent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Leander Fields McMillan Jincy Ann Bennett 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) John W. Leftwich - Son 10 Vermont Place, Bel Air, Md. 21014 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State Bel Air Memorial Gardens 5-2-97 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air, Maryland 22. Name and Address of Facility
HOward K. McComas III Funeral Home, P.A. wral Service Licenses 50 W. Broadway St., Bel Air, Md. loations that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, and act line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) 4-86Ls a SUB DURAL HEM ATOMA E NEVROLOGIC DEVISITION Examiner Donald So Wright MD Due to (or es e consequence of): Examiner attending physician and for use as the bunel-transit requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Box 68760. Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying seuse given in Pert I.

23b. Did

23b. Did Physician/Medical P.O. I signed by the a 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records. þ been sig Completed 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? The law certificate has b lirector, page 2 s 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No of Vital 25. Wes case referred to medical exeminer? director Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☑ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA this funeral 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of : After ! Certification: 28c. Injury et Work? 28d. Describe how Injury occurred Division 5 Pending investigation 1 Naturel ARIL 27,1997 death. PM 1 Yes 2√ No Slipped and fell-> Hit 4 e ofter death filled in by the 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc, (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled is 1314 Conowingo Rd, Belfir, Md Home Certifying Physicien: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29a. Certifier Medical Tell Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) neu

State Registrar 31. Dete filed (Month, Dey, Yeer) MAY 2 1997

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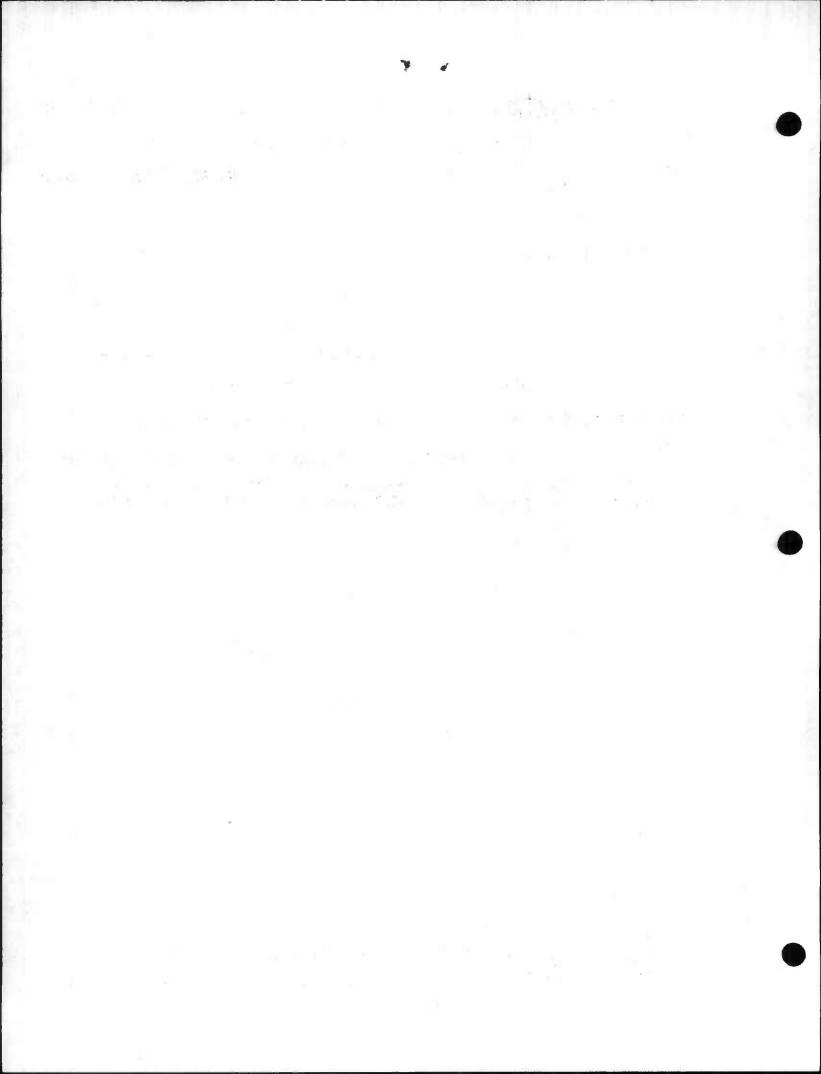
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dress of person who completed cause of deeth (Item 23e) (Type, Print)

Gillette

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 9 7

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			1. Decedent's Nama (F	irst, Middle, Li	ast)								2. Date of D			Veer	3. Time o	of Death
	Physic /Medi		Margaret	F.		Lino	des						April	28 .	1991	Yaar 7	1:5	OPM
	Exami		4a. Facility Name (If no								4b. City, To	own, or Lo	ocation of Dea	1		of Death		
4	Exami		269 Parad	ise Roa	ad						Abe	rdee	n	T	Harfo	bro		
۳	Funeral		5. Social Sacurity Numb	per 6.	Sex	7. Ag	e (In yrs. last	birthday)	If Unda		r if Under	24 Hrs.	8. Data of B	irth	ICILIC		iaca (Stata	or Foreign
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	d within 72 hours after deeth with the Maryland ilene. If then "natural", or flems 23a or 28a-f show the Medical Examiner must be notified at	Funeral		grse w			5 l= 11.0	10.1	Mar David		1001	1 1-0 10					(- 1)	
	b he d	5	11. Marital Status		12. Was Dec	orces?		13.	f Yes, spe	cify Cu	ban, Mexica	n, Puarto	ecify Yas or N Rican, etc.)	10-		k, White,	an Indian, etc.	
20	s aft	by F	1 Never Married		1 ☐ Yes If Yes, G	iva	No		I □ Yas	2/2 No	Specify.	:			Specify	. Whi	te	
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Na Sa	should be nd Mental marked o	2	Michael	Walsh							Es	tell	a Ry	an				
Maryland 21215-0020	s 1 and 2 should be filed I Health and Mental Hyg tem 27 is marked othe other treumetic event,		19e. Informant's Name	/Ralationship	(Type, Print)		1	9b. Mailir	g Addres	s (Stree	et and Numb	er or Run	al Route Num	ber, City o	or Town,	State, Zip	Code)	
	1 and 2 Health em 27 i		Peggy Deal	(daugh	nter)			269	Para	dise	e Road	, Ab	erdeen	, MD	2100	01		
re	f He fem		20a. Method of Disposit				20b. Placa	of Dispo	sition (Na	ma of	ace)		Date	20c. Lo	cation -	City or To	wn, State	
9	Page ent c ent c y or		1 Burial 2 □Cı 4 □ Donation 5 □			State	Mt. E					5	/1/97	Havr	e de	e Gra	ice, M	D
altimore,	permit. Page Department o Important: If i any injury or once.		21. Signatura of Funera			-		22	Name a	nd Add	ress of Facili	ibr						
Ba	permit. Pages 1 and Department of Heat Important: If Item 2 any injury or other once.		1	Λ	27 - 27	· In							ral Ho	me, P	A.			
_		_	burren	Hory	ungi	ex	lee	Į.	berd	een	, Mary	land	21001	-3399)			
п			23a. Part1. Enter the d shock, or haart fai	isease, or con ilura. List oniy	plications (Hat one cause on	caused each lin	I the daath. D na.	o not ent	er the mod	de of dy	ring, such as	cardiac	or respiratory	arrest,		1	Approxima Intarval Be	te tween
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	/Medical Examiner		Immediate Cause (Fina disaase or condition	il	ter	WY	the c	Mo	me	00.	STACO	we	Xun	Xa	1 ga	isk	.a	
П	Examine	l, s	resulting in death)		d		Due to (or es						1				_	
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	certificate be executed ding physician and ise as the buriel-transit	Examiner	Sequentially list condition	ons,	D		Due to (or as	a conseq	uence of):	:			·			· i		
Ö,	e axe ian e uriel-		Sequentially list conditi- if any, leading to immed cause. Enter UnderlyIn Cause (Disease or Injur	g												I		
68760,	ata b nysic ne b	Medical	thet initiated events resulting in death) Last		C		Due to (or as	a conseq	uenca of):							1		
9	certifice nding ph	Zec														1		
Box	E 3				d													
M	law requires that the death as been signed by the etter 2 should be detached for u	Physician	Part Ii. Other significan	t conditions	contributing to d	death bi	ut not resulting	in the ur	ndertvina o	cause o	iven in Part	l.	23b. Did	tobacco	use con	ntribute to	the cause	of death?
P.O.	by th	Ę.	1 0 000	1.0	Part	1	74:011	12					15	Yes 2	□No	3□ Prol	pably 4	Unknown
	w requires thet been signed to should be deta	by P	congress	me.	War)ou pu						2	2.00			,	,
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Ë	Physician: The ratio continuate or the continuat	Be	25. Wes case referred to exeminer?	o medicel	11							e of Deet	h (Check only	one)				
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Division of	ng P fter t	on:	27. Menner of Deeth 1. Naturel 5	☐ Pending	28a. Date (Mor	of Injui	y Year) 28t	. Time of Injury	1	28c. Inji W	ury et ork?		28d. Déscribe	how Injur	y occurr	red		
000	endili seth. or: A he fu	ati	2 Accident	investigatio					М		Yes 2	No						
ž	ar der	tiff	3 ☐ Suicide 6 4 ☐ Homlcide	Could not be determined	28e. Plac	e of Inju	ury - At home, (Specify)	farm, str	et, factor	y, office			28f. Location City or To	(Street and	d Number	er or Rura	l Route Nur	mber,
	s effective	Certification:		/			, , , , , ,						,					
	To the Hospital or Attending Physician: The is within 24 hours efter deeth. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	cal	29a. Certifier 12	Certifying Ph	ysician: To the	e best o	f my knowled	ge, death	occurred	at the t	time, date an	d placa,	and due to the	e cause(s)	and ma	nner as st	eted.	-
	n 24 n 24 ne Fu	edical	one)	medical Exar	niner: On the t and mar	ner sta	examination a ited.	and/or inv	restigation	i, in my	opinion, dea	ith occurr	ed at the time	, date and	piace, a	and due to	the cause(5)
	withi To the	X	29b. Signature and title	of certifiar	561		/		29	c. Licer	sa number			29d. Dat	te signed	(Month,	Day, Year)	
			Mine	x vin	(Clm)	/				DS	736	9-		Aby	d:	28.	199-	-
			30. Name and address of	of person who	completed cau	sant d	eath (Item 22) (Tune	Print\	V	0	1		(10				7
			19 1,10km	ut /	and:	H	281200	// (Type,	H	GN	wxan							
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DHMH 16 Rev 6/95

From American Survey State Company

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month 320 **Physician** Betty Little gield Anne An you /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bel Air Nursing & Rehabilitation Center Bel Air Harford 7. Age (In yrs. last birthday) If Undar 1 Yaar 5. Sociel Sacurity Number If Under 24 Hrs. 6. Sax 8. Dete of Birth (Month, Day, Year) Birthpleca (Stata or Foreign Country) **Funeral** Months Deys 1□M 2/□F Hours Yrs. Director 66 028-24-4296 March 24,1931 Massachusetts Usual Residence of Decedent death with the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at 1 Yes 28 No Directo Maryland Harford Bel Air 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1020 Seamount Rd. 21015 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 14. Rece - American Indian. Bieck, Whita, atc. pernit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "naturelt, or then any Injury or other traumetic event. The statements any Injury or other traumetic event. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detas: 1 ☐ Never Merried 2K Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☒ No Specify: Specify: 3 White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedent's Usuei Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumama) Be Philip Irving Light Anne (nmn) Souter 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Littlefield - Husband 1020 Seamount Rd., Bel Air, Md. 20b. Piece of Disposition (Name of cametery, cramatory or other place) 20c. Location - City or Town, Stata 20e. Method of Disposition 1 ☐ Buriel 2 A Cremation 3 ☐ Removal trom Stete 4-25-97 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. W. Chester, PA 21 Signature of Funeral Service License 22. Name end Address of Fecility Howard K. McComas III Funeral Home, P.A. Comas 1317 Cokesbury Rd., Abingdon, Md. 21009 is the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and fully one cause on each line. Approximeta Interval Between Onset and Daath Physician /Medical Immediete Cause (Finel Breast Concer GYPARS disease or condition resulting In death) Examiner Examiner physician and s the burlal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to Immediete cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting In death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): 80 been signed by the attending should be detached for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy tindings available prior to Completed 24e. Wes an autopsy performed? completion of cause of death? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Wes case refarred to medical 8 28. Pleca of Deeth (Check only one) exeminer? Hospitei: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No funerai 28e. Dete of Injury (Month, Day Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Neturel 2 Accident 5 Pending 1 Yes 2 No Investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the cause(s) and menner es steted.
2 Medical Examiner: On the best of axemination and/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the cause(s) end menner steted. edical 29e. Certifier completely 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) 134052 30. Neme and eddress of person who completed cause ot deeth (Item 23e) (Type, Print) Bel Air Maryland 21014 Ave.

State Registrar 32 Registrar's Signeture

State of Maryland / Department of Health and Mental Hygiene 97

						Cei	rtificat	e of	Death		Be	eg. No.			
			1. Decedant's Nama (First, Middle, La	st)							2. Date of Deat	h	201	3. Tir	na of Death
	Physic		Robert Wil	liam Lo	ove, Si	· .					Month April	Day 2.7 1	Year 997	51	PM
1	/Medi Examii		4a. Facility Nama (If not institution, give	e street and number)					4b. City, To	wn, or Lo	cation of Death	4c. County)	r M
	Examili	iei			/				A	- 1 .				1 - 1	,
-	Contains.		695 Americana 5. Social Security Number 6. S		(In yrs. last b		If Under	1 Yaar	Ann ar		8. Date of Birth		e Aru		
	Funeral Director			Day of F	92	Yrs.	Months	Days	Hours	Min.	(Month, Day, June 11	Year)	Wash:	ifry)	ate or Foreign
			Usual Rasidance of Decedent								Julie 11	1704	Wasii.	riigt	OII
	land M		10a. Stata 10b. County		10c. City, Tov	vn or Lo	cation						1	0d. Insk	da City Limits
	Many 4 sh	ō	MD Anne Aru	inde1		Anns	apoli	c						1/1	Yas 2□No
	15 th	Director	10e, Street and Number	11001		2311110	10f. Zip				11	Og. Citizan of	What Cour		
	With and and and and and and and and and and	ā	695 Americana Dr	ive #4A			7011 2116		21403		,	United			
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental hygiena. If the 12 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	Funeral		12. Was Decedant Ev	ran in II C	12.1	Man Dagge			nln2 (Cn.	aif. Vac or No		e - Amaric		
	item item	5	11. Marital Status 1 Nevar Married 2 Married	Armed Forces?		13.1	f Yes, spec	ify Cuba	an, Maxican	, Puarto	ecify Yas or No- Rican, atc.)		ck, White,		W1,
2	s aff	by F	3 Widowed 4 Divorced	1 ☐ Yas 2 ☐ No If Yas, Give XX Yaar or Dates:	,		1 ☐ Yas 2	2 XNo	Specify:			Specif	y: T.Th. 2		
3	hou				100	Dense	danala Idawa	10	-At			105 Kind of D	Whi		
Maryland 21215-0020	"nar	Completed	15. Decedent's Ed (Specify only highest gra		168	(Giva	dent's Usue kind of wor DO NOT us	k dona	during most	of worki	ng	16b. Kind of B	usiness/inc	dustry	
7	within one.	E	Elementery/Secondary (0-12)	Collaga (1-4or 5+))				۵)						
N D	ther int.		17. Fathar's Name (First, Middla, Last)	6		EX	kecuti	rve	18 Mothe	r'e Nama	(First, Middle, A	Retail		ces	
Ž	od od	Be							To. Motrie				iia/		
Ž	2 should and Mer is marks	2	William James Lo								y Bartle				
<u>a</u>	2 shd and is m		19a. Informant's Name/Relationship (.						l Routa Number				
1	and aalith n 27 ner t		Robert William Lo	ve, Jr (So	-				ive A	nnap	olis, Ma				
altimore,	of H		20a, Mathod of Disposition 1 □ Burlal 2 □ Gremation 3 □	Demovel from State	20b. Placa o	of Dispo a <i>ry, cre</i> n	sition <i>(N</i> am na <i>tory</i> or o	na of ther plac	ce)		Data :	20c. Location	- City or To	wn, Sta	ta
Ē	permit. Pages 1 and 2: Department of Haalth ar Important: If Item 27 is any injury or other traugnes.		4 Donation 5 Other (Specifi)	Ft. L	inco	oln Cı	rema	tory	Apri	1 29 199	7 Bren	twoo	1 м	arulano
<u> </u>	partit.		21. Signature of Euneph Septice Licen	see		22	. Nama an	d Addre	ss of Facilit	John	n M. Tay	lor Fu	neral	Hor	ne. Inc
מ	88558		1 Novan	\sim		1	47 Du	ke o	of Glo	ouces	ster St.	Annap	olis,	MD	21401
	_		23a. Part1. Enter tha disaasa, or son shock, or haart failura. List only	that caused th	na daath. Do									Approx	
	Physician		snock, or haart failura. List only	ona causa on aach lina.									i	intarva Onsat	i Between and Death
1	/Medical		Immediate Cause (Final	contra	DAT								į		
	Examiner		diseasa or condition rasulting in death)	. acute									<u>i</u>		
		ē		CHE	ua to (or as a	conseq	uence or):						i		
	uted ansit	Examiner		b. CIII			100000								
,	axec n an ial-tn	Exa	Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Causa (Disease or Injury	00	ua to (or as a	conseq	uanca oi).						1		
58/5U,	sicia bour		Causa (Disease or Injury that initiated avents	C	un to /or on o										
0	ficat phy ss th	edical	resulting in death) Last	00	ua to (or as a	conseq	uanca or):								
Š	law requires that the death certificate be assocuted as been signed by the attending physician and a 2 should be datached for usa as the burial-transit	3		d											
Ď	r requires that tha death co been signed by tha attend should be datached for us	Physician/	D. All Cabour In Manager In the								1		1		
	y tha	ys	Part II. Other significant conditions of	onthouting to death but	not rasulting	in the ur	ndariying ci	ausa giv	an in Part I.						use of death?
<u>,</u>	that deta	P	Dro stute	Ch							1 L Y	98 2□ No	3 Prol	bably	4 ☑ Unknown
Records,	sign d be	d by	,								24a. Was a	n autoney	24b W	ara auto	osy findinos
Ö	peed	Completed									perform	ned?	co	allable p	rior to
ě	has has	dm											of	deeth?	
33	cata h							_			1 □ Ya	s 2 XNo	10	Yes	2□ No
VII	Physician: Tha I rthis certificate ha	Be	25. Was case refarred to medical axaminer?	Hospital:				0.11		of Death	(Check only on	a)			
	Physi this ral dir	P	1 Yas 2XXVo	1 L Inpatiant					4 LI NU		na 54 Rasida			y)	
Division of	ding P. h. Aftar I	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Panding	28a. Data of Injury (Month, Day Y		Time of Injury		8c. injur Wor			28d. Dascribe ho	w Injury occur	red		
20	endil Bath. Dr. A the fu	ati	2 Accidant Investigation				М	1 🗆	Yas 2 1	No					
Ĕ	or Attending Fattar death. I Director: Aftar d in by the funar	Certification:	3 ☐ Suicida 6 ☐ Could not be datarmined	28a. Place of Injury building, atc.	y - At home, f (Specify)	arm, str	aat, factory	, office		2	28f. Location (St. City or Town	reet and Numi	ber or Rura	/ Route	Number,
ב	Ta af o lie														
	To the Hospital or within 24 hours after To the Funeral Dir complataly filled in	edicai	29a. Cartifiar 1 Certifying Phy (Check only 2 Medical Exam	valcian: To the best of ri inar: On the basis of ex	my knowledg	e, death	occurred	et the tin	ne, dete en	d place, a	and dua to the ce	eusa(s) and m	annar as si	tated.	sea(e)
	in 24	Pa	one)	and menner stete	id.	10001111	astigation,		pinon, daa	ur occurr	oo at tha time, or	ato and place,	and dua to	ora car	330(3)
	To To To To To	Σ	29b. Signatura and title of certiller	1000				Licens D08	e number		2	9d. Date signe	d (Month,	Day, Ye	er)
			Jelle	Se				סטע	1 24			April	28, 1	997	
			30. Name and address of person who o	completed cause of dee	th (Item 23e)	(Туре,	Print)								
			Jack R. Lichtens	tein, M.D.	207 R	ide 1	ev Av	enu	e Anna	apol i	is, Marv	land 2	1401		
	Sta	ite	31. Data filed (Month, Day, Year)	32. Registrar's	s Signatura						,				
	Registr	ar	MAY 0.1 1997	gana Da	widson-	fande	1								
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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Deeth **Physician** AGNES NMN LLEWELLYN APRIL 25,1997 7:30 /Medical 4e. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 5 Social Security Number 8. Date of Birth (Month, Day, Year) Mar. 14, 1921 7. Age (In yrs. lest birthday) Birthplace (Stele or Foreign Country) **Funeral** 1 □ M 2 🕅 F Deys Hours 76 Yrs. Director 214-30-9770 GERMANY Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show TYPYes 2□No Director MD ALLEGANY LAVALE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with "natural", or items 23a or outcal Examiner must be 1208 NATIONAL HIGHWAY 21502 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Hem any injury or other traumatic event, the Medical 1 Never Merried 2 Merried 1 ☐ Yes 2X No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specity: þ Specify: WHITE 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 1) Manager 2) Inspector 1)Cleaners 2) Fire Dept. 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PAUL SUSCHKE 9 AGNES LISNER 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ROGER LLEWELLYN / STEP-SON 412 CHESTNUT ST., CUMBERLAND, MD 21502 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 XBurlal 2 Cremetion 3 Removal from State SUNSET MEMORIAL PARK 4 ☐ Donetion 5 ☐ Other (Specify) 4/28/97 CUMBERLAND, MD 22. Name end Address of Fecility
GEORGE-UPCHURCH FUNERAL HOME, P.A.
CIMBERLAND, MD 21502 21. Signature of Funeral Service Licensee 23e. Pert1. Enter the alsease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediate Ceuse (Final disease or condition resulting in death) **Examiner** 24 hrs s the burial-trans Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, ncepalo Physician/Medical signed by the al Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2030803 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 2. No 1 ☐ Yes 2 No To the Hospital or Attanding Physician: within 24 hours after death.

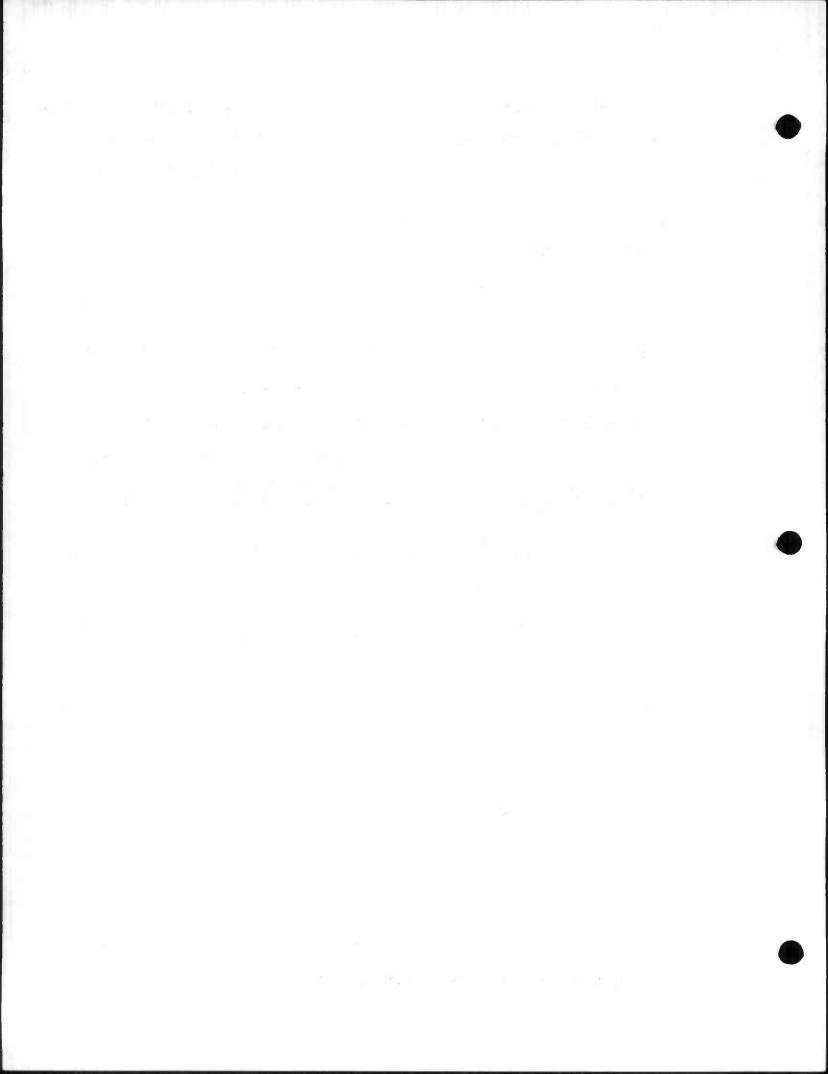
To the Funeral Director: After this certification completely filled in by the funeral director. 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 20 No Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Sireel and Number or Rural Roule Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated. 29a. Certifier Medical 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Hma Shalin MD April 25# 1997 D46346 1268 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) HUNA SHAKIL 625 KENT AVE. CUMBERLAND, MD. 21502 31. Dete filed (Month, Dey, Year) 32 Registrer's Signeture

DHMH 16 Rev 6/95

Registrar

APR 3 0 1997



State of Maryland / Department of Health and Mental Hygiene

Phy	sician
/M	ledical
Exa	miner

Funeral Director with the Maryland or 28a-f show

items 23a death Pages 1 and 2 should be filed within 72 hours after tent of Health and Mental Hygiena. nt: If Item 27 is marked other than "natural", or Ite traumatic event, the Medical

Physician /Medical Examiner

Examiner sician and burial-transit physician s the buria Physician/Medical signed b þ Completed ate has Be Certification: To

Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 s Department of Health an Important: if item 27 is any Injury or other trau The law requires that the death certificate be executed P.O. Box 68760, Records, Division of Vital To the Hospital or Attending Physician: I within 24 hours aftar death.
To the Funeral Director: After this certifica completaly filled in by the funeral director, p State

Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death APRIL 26 1997 LOGSDON 11:05 PM GLADYS 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) if Undar 1 Yaar 5. Social Sacurity Numbar 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 1□ M 2□XF WEST VIRGINIA Yrs. 232-29-9249 Nov. 12,1902 Usual Rasidanca of Dacadant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Director MINERAL PATTERSON CREEK 10a. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? ROUTE 3, BOX 298 26753 U.S.A. Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? Was Dacadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amaricen Indian, Black, Whita, atc. 1 ☐ Yas 2 MNo If Yas, Giva Yaar or Datas: 1 □ Navar Married 2 □ Marriad 1 ☐ Yas 2 ♥ No Specify: Specify: WHITE þ 3 X Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Educetion 16b. Kind of Business/Industry (Specify only highast grada complated) Elementary/Secondery (0-12) College (1-4or 5+) UNKNOWN HOMEMAKER HOME 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Be JOHN H. LONG EFFIE DORMAN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) JOHN LOGSDON / SON P.O. BOX 306, FT. ASHBY, WV 26719 20b. Placa of Disposition (Neme of cematary, crematory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata FORT ASHBY CEMETERY 4/30/97 FORT ASHBY, WV 4 ☐ Donation 5 ☐ Othar (Spacify) 21. Signature of Funaral Sarvice Licensas 22. Nama and Addrass of Facility
UPCHURCH FUNERAL HOME INC 23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cerdiac or raspiratory errest, shock, or haart failura. List only ona causa on each line. Approximete intarval Batween Onsat and Daath Immediata Causa (Final Cardiopulmonary Arrest One Hour disaasa or conditior rasulting in daath) Due to (or es a consequance of) Intractable C H F One Week Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cousa (Disaasa or Injury that initioted evants rasulting in daath) Last Due to (or es e consequance of) Dua to (or es a consequence of):

Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. Pneumonia

25. Wes cesa rafarrad to madical axaminar? Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yas 2 No 27. Mannar of Death 28c. Injury at Work?

28b. Tima of 28a. Date of Injury (Month, Day Yaar)

28a. Place of Injury - At home, farm, straat, factory, offica building, atc. (Spacify)

23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to complation of ceusa of daath? 24a. Was an autopsy performed? 1 Tas 1 ☐ Yas 2 ☐ No

26. Place of Deeth (Chack only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, Stata)

🙇 Certifying Physicjan: To the best of my knowledga, daath occurrad at tha tima, data and place, and dua to tha causa(s) and mannar as stated. On the basis of examinetion end/or invastigetion, in my opinion, death occurred et the time, dete end place, end due to the cause(s) and manner stated. 29g Pate signed (Month, Day, Year) 29c. Licansa number

1 ☐ Yas 2 ☐ No

D 16041 30. Nama and eddrass of Jerson who complated causa of daath (Itam 23a) (Type, Print)

TERRY WILLIAMS M.D., 500 MEMORIAL AVENUE, CUMBERLAND, MD 21502

1 Natural
2 Accidant

3 Suicida

29a. Certifier

29b. Signature an

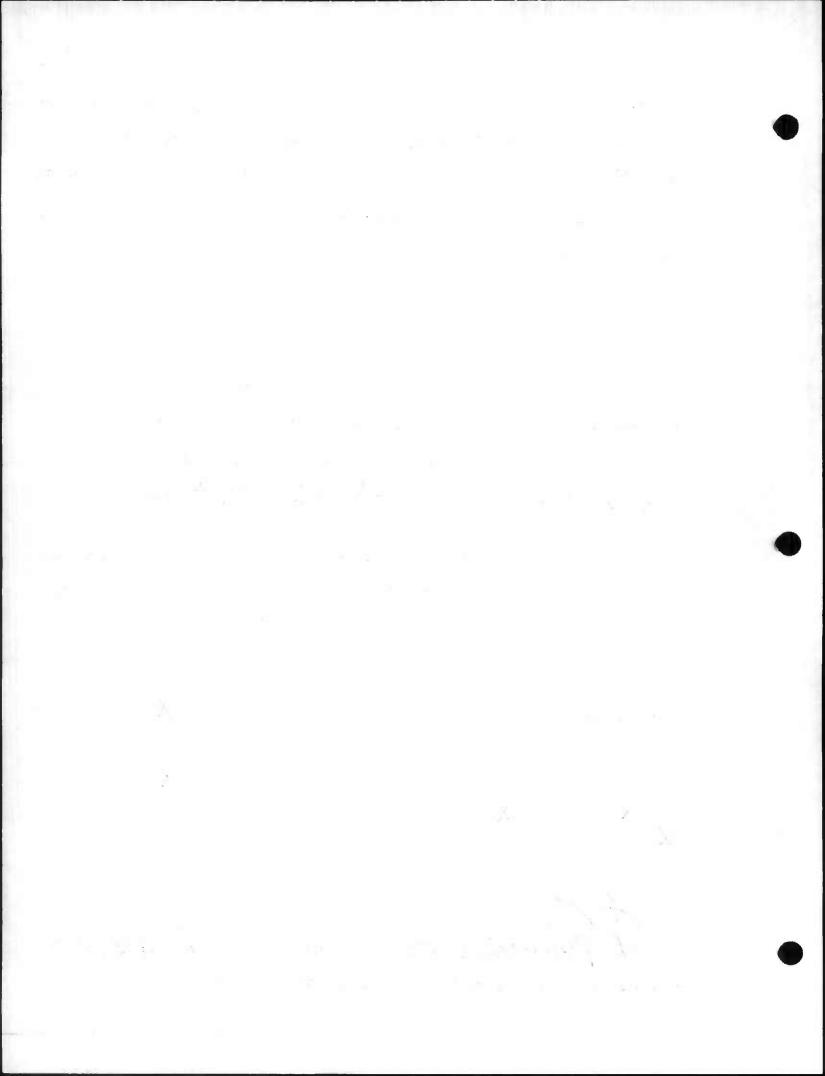
Medical

4 Homicida

5 Pending

Invastigation 6 Could not be





STATE OF MADVIAND / DEPARTMENT OF BEATTH AND MENTAL BUCKENE

	1 - STATE REGISTRAR	SIMIE UF N			ICATE (REG. NO	E .		
	1. DECEDENT'S NAME (First, Middle, Las	-						Ť	2. DATE OF	DEATH			TIME OF DEATH
	J HOWARD	LAYMA	.N						APR	24	19	97	8:10PM w
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. In	ast birthday)	IF UNDER 1 YE		UNDER 24	-	7. DATE OF (Month, I	BIRTH Day Mari		8. BIRTHPL. Country)	ACE (State or Foreign
	173-03-0544	1X M 2 □ F	92	YRS.	MONTHS DA	AYB HO	DURS	MIN.	NOV	11	1904		NESBORO PA
5	9a. FACILITY NAME (# not institution, give FAHRNEY KEEDY N		ME		96. СІТУ, ТО ВООЛ			OF DE	ATH		-	ASHIN	
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUN	TY		I soc CIT	Y, TOWN OR L	OCATION						10	d. INSIDE CITY
L DIRECTOR	7	HINGTON			NSBORC)						1	LIMITS?
FUNERAL	8507 MAPLEVILLE						2171	.3			10g. CITIZ		SA
E	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2 K	NO NO	If ye		Cuban,	Maxica	NC ORIGIN? n, Puerto Ric		or No—	Black, V	American Indian, white, atc.
	15. DECEDENT'S Ed (Specify only highest gra	HUCATION de completed)			USUAL OCCU		l worldna		16b, K	IND OF BU	SINESS/IND	USTRY	
COMPLEIED	Elementary/Secondary (0-12)	College (1-4 or 5	·) #	He. Do NOT u	perato		Working		0	il Co	mpan	ÿ	
5	17. FATHER'S NAME (First, Middle, Last)								ME (First, Mic		Surname)		
DE	Charles Detric	h Layman							Floo				
2	Marilyn L. Trac	У			Leiter					on or tow ynesl		PA 1	7268
	20a. METHOD OF DISPOSITION 10 Burlel 2 Cremation 3 Table 4 Donation 5 Other (Specify)	moval from State	cemetery, c	remetory or o	of disposition of their place) Cemet				4/27	1000		City or Town	, state PA 17268
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	- OLCON			ME AND A		OF FA					me, Inc.
	James ().	Bowler	DOC						Wayn				28
	23. PART() Enter the diseases, o shock, or heert failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a	ise on each lir	ne.	من	e mode	of dying	g, sucl	h as cardie	c or resp	iratory arm	eat,	Approximate interval Between Onset and Death
,			(011 740 74 00113	LOOLNOL C									
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	OUE TO	(OR AS A CONS	EOUENCE C	F):								
CERTIFICATION	CAUSE (Disease or injury that initiated events reaulting in death) LAST	DUE TO	(OR AS A CONS	EOUENCE C	F):								
	PART II. Other significent conditi	ons contributing to	death but not	resulting	In the under	rlylna c	ausa oly	ven In	Part I 2	4a, WAS AN	VARITTOREV	245 W	ERE AUTOPSY FINDINGS
PHTSICIAN: MEDICAL	Rehadiation				when		ouse give			PERFO	RMED?	A	AILABLE PRIOR TO
5									— II '	☐ YES	NO	0	F DEATH?
Σ	DID TOBACCO USE CON	TDIRLITE TO CA	LISE OF DE	ATH Y	ES [] NO		UNCE	DTAIN	I Z			1	YES 2 NO
A	25. WAS CASE REFERRED TO MEDICAL	T TO CA			TH (Check only		OIACE	KIAH	4 🗀				
2	EXAMINER?	HOSPITAL:			OTHER:								
١	27. MANNER OF OEATH	28e. DATE OF		26b. TII		c. INJURY	_	dence	8 Other (NJURY OCC	UREO	
	1 Netural 5 Pending	(Month, E	Day, Year)		JURY	WORKT	?	NO.					
	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE C	F INJURY — At I	home, ferm,	atreat, factory,	office						or Rural Rou	te Number,
2	4 Homicide determined	building,	atc. (Specify)						City or	Town, State	}		
COMPLEI	29a. CERTIFIER (Check only one) 2 MEDICAL EXAM	/SICIAN: To the best of											nd manner sa stated.
	29b. SIGNATURE AND TITLE OF CERTIF					-	9c. LICEN						
2		Bet mo				1	D (8						25, (99)
2	30. NAME AND ADDRESS OF PERSON N	VHO COMPLETED CAU	SE OF OEATH (IT	TEM 27) (Typ	s, Print)				- (
	VASANT DATTA	A 334	MILL	ST	HAGI	ERSI	OWN	I	MD :	2174	0		
	31. DATE FILED (Month, Day, Year)	Jahn Blues	AR'S SIGNATURE										
	WELL S O 1231	JULYA WELLEN		2			_	_					DHMH-16 Rev 1/6

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BU 68760

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month HARRY **EDGAR** LERCH Apr 1997 4a. Facility Name (II not institution, give street end number) 4c. County of Deeth 4b City Town or Location of Deeth WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 125M 2□ F Days Yrs 73 215-20-8248 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo MARYLAND WASHINGTON ROHRERSVILLE 10e. Street and Number 10f. Zip Code 10g. Cifizen of Whet Country? 20147 ROHRERSVILLE SCHOOL ROAD 21779 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ଔYes 2 □ No 1943− If Yes, Give Year or Dates: 1946 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) MACHINIST RAILROAD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HARRY E. LERCH SR. DAISY CASTLE 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY A. LERCH/WIFE P.O. BOX 119, ROHRERSVILLE, MARYLAND 21779 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY 5/02/97 LOCUST GROVE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name end Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ventricular fibrillation Due to (or as a consequence of): typesteusive candio vescular disease diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Last Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 28. Place of Death (Check only one)

Physician /Medical **Examiner**

the buriel-transit

USB 85

attending physician

this certificate

After

To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun

2

Certification:

Medical

Physician

/Medicai

Examiner

Director

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if flem 27 is marked other than any injury or other trainment.

3altimore, Maryland 21215-0020

Box 68760.

P.O. I

Records,

Division of Vital

Hospital or Attending Physicien:

the Manyland

Physician/Medical Examiner Completed Be

Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Non-intulin dependent dobetes wellitus

25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 56 ER/Outpatient 3 ☐ DOA 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27, Manner of Death 5 Pending Investigation 1 Natural 2 Accident

28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only onel

29e. Certifier

1 Certifying Phyeicfan: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and manner as stated.

2 Medicaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number

29b. Signature and title of certifier acarbonell, m.D.

D47942

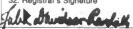
29d. Date signed (Month, Day, Year)

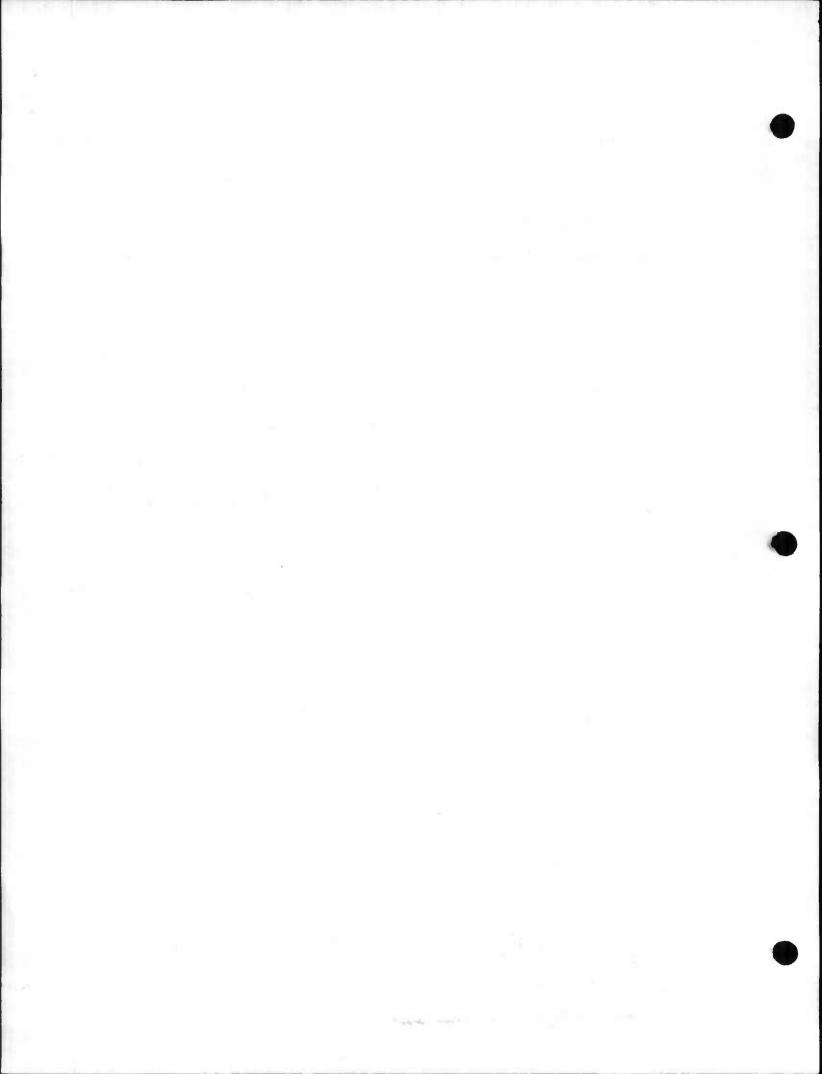
30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print)

12931 OakHill Ave. Hagerstown, MO21742 A. Juan Carbonell 32. Registrar's Signeture 31. Date filed (Month, Day, Year)

Registrar

0 2 1997



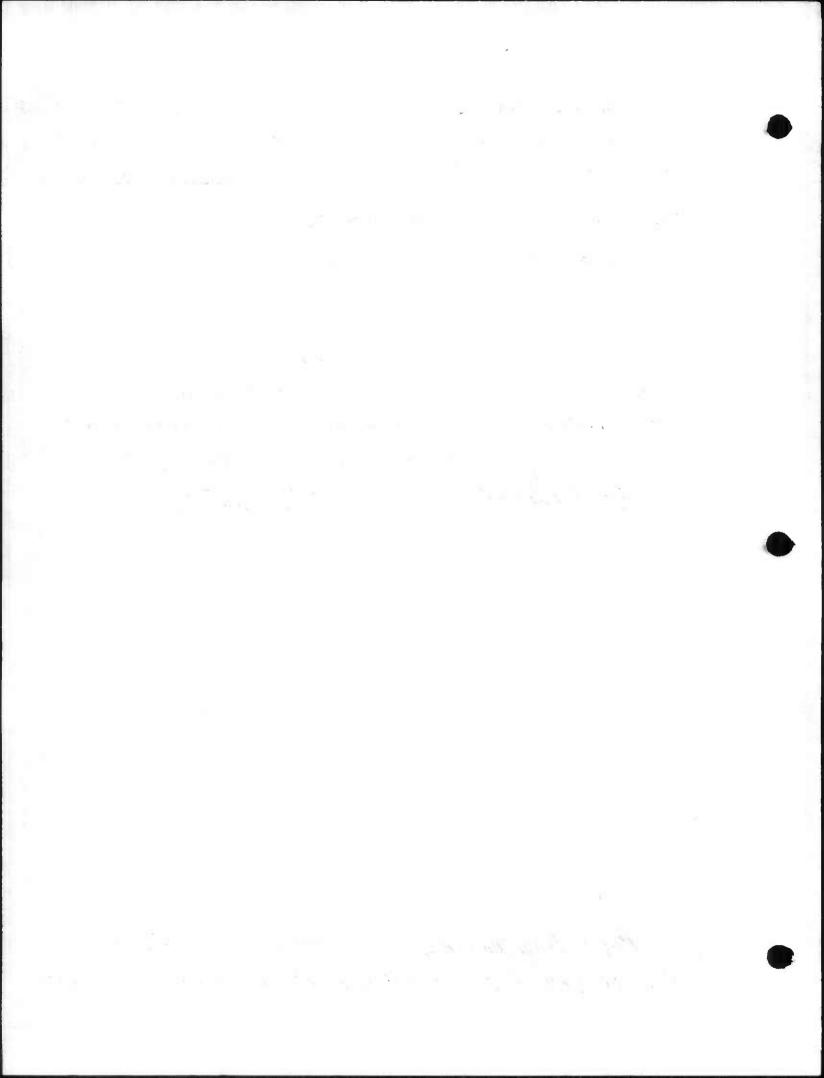


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Donna L. Miller /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Yeer | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2₩F 48 172-40-6577 Yrs. Director Sept. 15, 1948 Pennsylvania Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or flams 23s or 28s-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itama 23a or 28a-f ahov traumatic avant, the Medical Experience must be inclined at 1 Yes 2XXIo Pa. York Director Dover (Borough) 10a. Street end Number 10f. Zlp Code 10g. Citizen of What Country? IIO Dogwood Drive Funeral 173|5 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compl Elementary/Sacondery (0-12) College (1-4or 5+) School Teacher Education 17. Father's Name (First, Middle, Last) 2 Robert H. Williams Rita E. Bovard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stewart P. Miller 110 Dogwood Dr., Dover, Pennsylvania 17315 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cametery, crematory or other piece) 20a. Method of Disposition W. Manchester Twnshp © Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Shiloh Cemetery 4-30-97 4 Donation Cother (Specify) York, Pa. 22. Neme end Address of Facility The Burbage Funeral Home 108 William St., Berlin, Md. 21811 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart lailure. List only one cause on each lina. **Physician** /Medical Immediata Cause (Final disease or condition rasulting in death) Examiner Physician/Medical Examiner attending physician end for use es the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed s certificate has b 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attanding Physician:
 124 hours effer death.
 Funeral Director: Affer this certifical eleigh filled in by the funeral director. p. Was case examiner? No 25. Was case referred to medical 8 28. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 3 DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 28e. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Naturel 5 Pending 1 Yas 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner as stated.

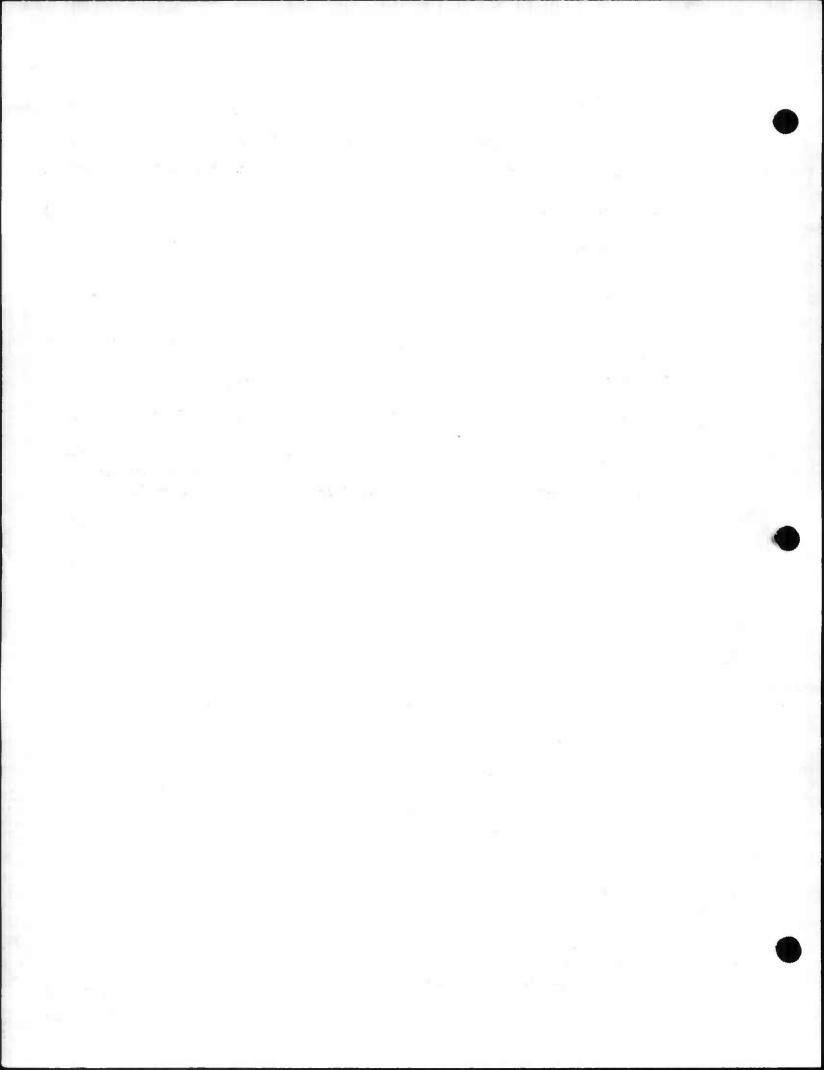
2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and due to the causa(s) and mannar stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signature of title of g 29c. License number 0 32. Registrar's Signatura State 9 1997 Registrar

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene 14583 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Year PHYLLIS MATTHEWS APRIL 11.20 Am 26-1997 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ChINTON MARYLAND GEONGES DUT HERD HOSPITAL PRINCE If Under 24 Hrs. 8. Dale of Birth (Month, Day, Jan 15, 5. Social Security Number If Under 1 Yaar 6 Sax 7. Aga (In yrs. last birthday) 9. Birthpiece (State or Foreign Country) Lakeport, N.H. **Funeral** 1□M XXF Months Days Director 063-09 9879 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 Yes 2 No Upper Marlboro Maryland Director Prince George's 10f. Zip Code 20772 10g. Citizen of What Country's United States ŏ 9205 Columbine Lane Нети 23а Funeral Race - American Indian, Black, White, etc. 12. Was Dacedent Ever in U,S. Armed Forces? Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, atc.) permit. Peges 1 and 2 should be filed within 72 hours efter Department of Health and Mantal Hygiene. Important: If Item 27 Is marked other than "natural", or ite any injury or other traumatic avent, the Madical Examina page. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 🏋 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Operator Telephone Company 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Ruffell Evelena Harold 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 20772 19a. Informant's Name/Relationship (Type, Print) 9205 Columbine Lane, Upper Marlboro, Maryland Dawn Gregory 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, State 1 ☐ Buriai XXCremation 3 ☐ Removal from Stata Lee Crematory April 29, 1997 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each tine. Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical 2 days Cerchrown cular accident Examiner Due to (or as a consequence of): Physician/Medical Examiner iding physician and isa as the buriel-transit Hospital or Attanding Physician: The law requires that the death certificata be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of) usa as ed by the e Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s been signed be should be dete Hypertension Division of Vital Records, þ Completed 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy atrul physilation pege 2 certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No director, 86 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this funeral 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 5 Pending Investigation 1 Neturel s after death. 1 Yas 2 No 2 Accident filled in by tha 3 Suicide 6 Could not be determined 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homleide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a Certifier ş 29b. Signatura and titla of certifier 29d. Date signed (Month, Day, Year) 29c. Licansa numbar m 38388 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) WoodyAnd Rol 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 3 0 1997 Registrar



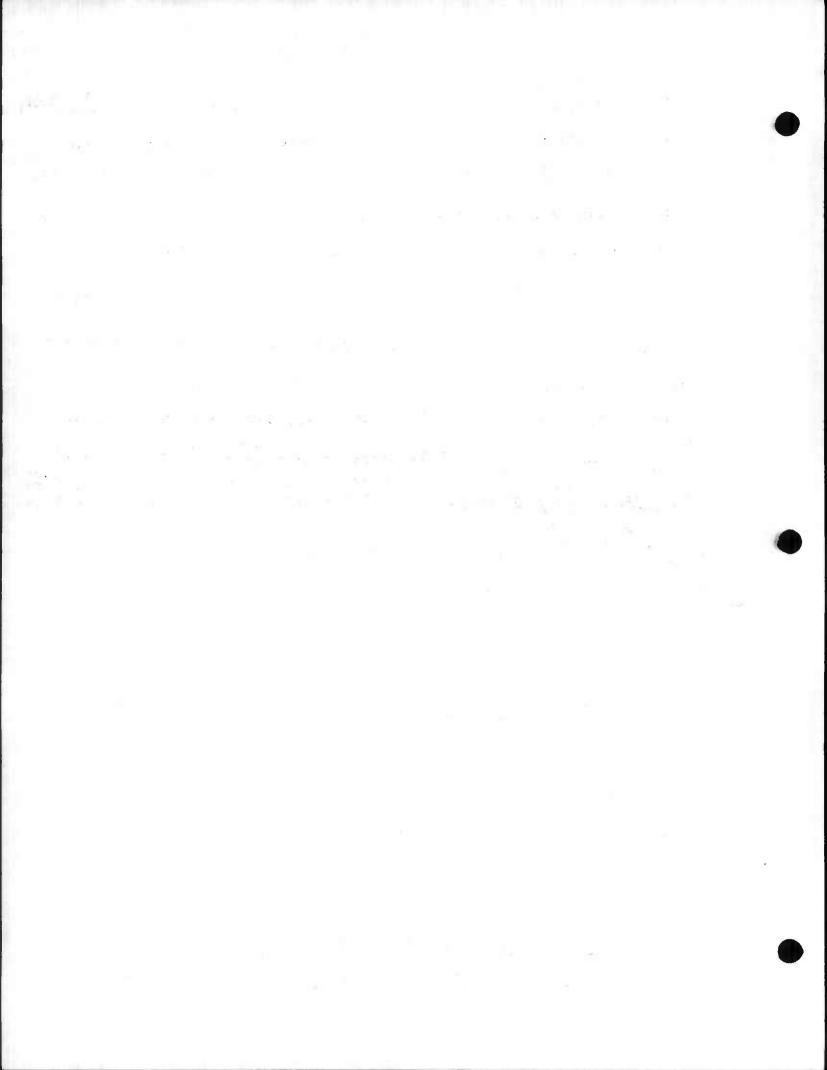
State of Maryland / Department of Health and Mental Hygiene 97 11.581

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	Sta		31. Dete filed (Month, Day, Year)	32. Registrer	r's Signature	_	ANDKE	WS AIR FO	UKUE BAS	E MD 20	762-	6600
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State of Maryland / Department of Health and Mental Hygiene

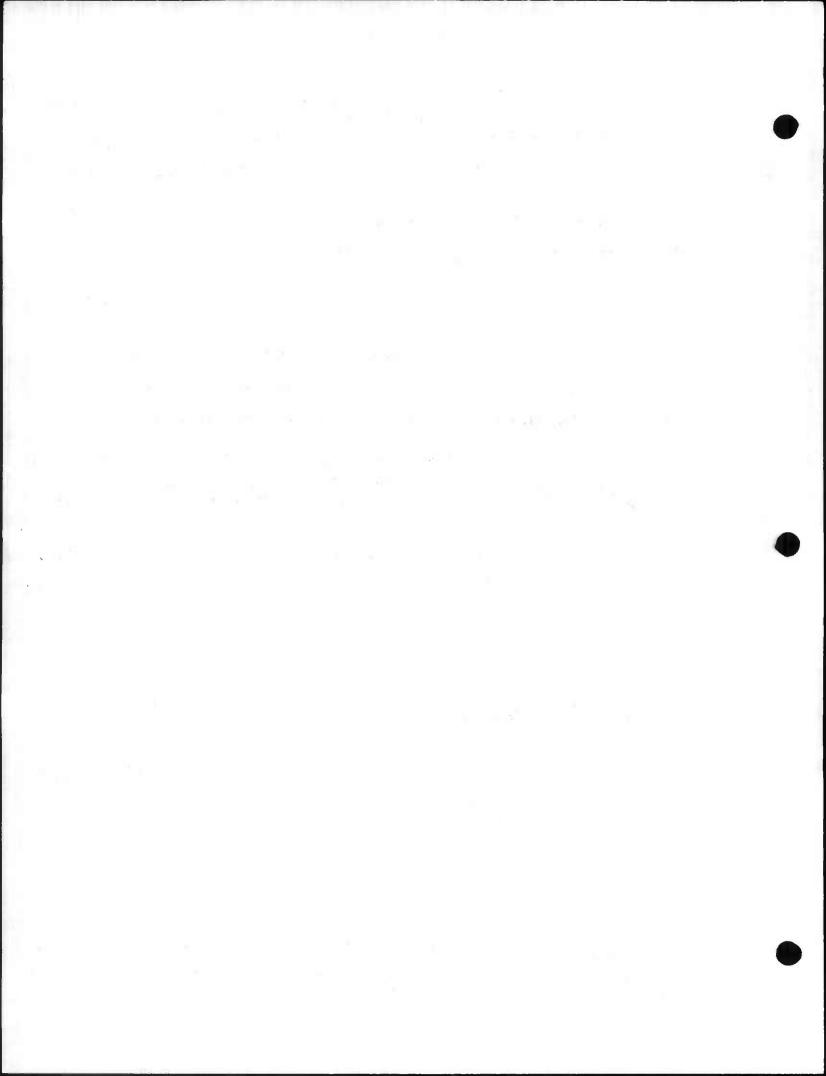
						Cer	tificate of	Death	F	leg. No.	1	4585
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21215-0020	be filed within 72 hours after death with the Maryland nat Hygiene. Identify than "natural", or Nems 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Maritat Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ⊠ Yes 2 □ Note of Yes, Give Year or Dates:	J,S.		/as Decedent of Yes, specify Cul ☐ Yes 2 ☑ No	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ica - Americ ack, White, ify:	
5-0	72 h	eted	15. Decedent's Ed (Specify only highest gre	ducetion	18a.	Deced	ent's Usual Occu	ipation a during most of work	ring	16b. Kind of E	3usiness/Ind	dustry
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)				e during most of work ed) lice For		State	e of	Maryland
	Hygiel wither the	S	1 2 17. Father's Name (First, Middle, Last)		01	7	Tal 10					
Maryland	d be f intal h ed of	Be C						18. Mother's Nam			me)	
2	2 should be end Mental is merked o aumetic eve	ပို	Edward Murph 19e. Informent's Name/Relationship (19h	Mailin	Address (Stree	et and Number or Rui		gent	Ctate 7ir	Code
M	and 2 salth er 27 is or trau		Mary Murphy/wi					rive, Se				
Baltimore,	ns 1 and 2 should of Health end Mer Item 27 is merke r other traumstic		20a. Method of Disposition				ifion (Name of atory or other pla			20c. Location		
E O	permit. Papes 1 a Department of Her Important: If item any injury or othe once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific					emetery1	ay 1	Crown	svill	le, MD
=	Departm Departm Importar any inju		21. Signature of Funeral Service Licer		\ ,	22.	Name and Addr	ess of Facility	991	_		Home k Funera
The same	Physician /Medical Examiner	lher /	23a Farty Erfler the disease, or company to the process of company to the process of company to the process of company to the process of condition resulting in death)	Respi	cato or as a co	D 19 consequ	Failinence of):	ure ance			1 1 1	2 morth 3 years
	and the	Exam	Sequentially list conditions,	Due to (or as a c	onsequ	ience of):					0
68760,	rifficate be exectly physician aq	edical E	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C. Due to (or as a c	onsequ	ence of):					
Box 68		-5	resulting In death) Last	d								
	es thet the death ce igned by the ettendii be detached for use	Physician/I	Daniti Other stanidisent and datase									
P.O.	the c	hys	Part II. Other significant conditions of		_	ithe un	derlying cause g	iven in Part I.		obacco usa c	. /	o the causa of death? bably 4 Unknown
	s thet	by Р	Jéver	e anemia	J				101	48 2□ NO	SUPPLO	bably 4 Onknown
Records,	v requir been s should	Completed t							24e. Wes a perfor		av.	ere autopsy findings ailable prior to impletion of cause death?
<u>۳</u>	ysician: The lav is certificate hes director, pege 2	Соп	/						1 □ Y	es 2000	10	☐ Yes 2☐ No
/ita	clan: entific ector,	Be (25. Wes case referred to medical examiner?					28. Plece of Deel	h (Check only or	ne)		
2		To	1 ☐ Yes 2 ☐ No		ER/Out	•	3LI DOA		me 5 Aesid			y)
Division of Vital	To the Hospital or Attending Physician: within 24 hours effecteeth. To the Funeral Director: After this certification plainty filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Sulcide 6 Could not be		28b. T	ime of njury	28c. Inju Wo M 1	ury at ork?] Yes 2 No	28d. Describe h	ow injury occu	rred	
Σ	al or At s efter d il Direct ed in by	Certifi	4 Homicide determined	28e. Plece of Injury - At h building, etc. (Speci	iome, far	rm, stre	et, factory, offica		28f. Location (S City or Tow		ber or Rura	al Route Number,
	To the Hospital or Attend within 24 hours effer deet! To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one)	ysician: To the best of my known the common warmen and manner stated.	owledge, ation end	, death d/or Inve	occurred at the t estigation, In my	time, date and place, opinion, death occur	and due to the c red at the time, o	ause(s) and <i>n</i> late and place	anner as st	tated. the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	.1			29c. Licen	nse nu <i>m</i> ber	2	9d. Date sign	ed (Month,	Day, Year)
				11	-1	W. L	D	120431		4/31	5/97	,
		3	30. Neme end address of person who	completed cause of deeth (Ite	m 23e) (Туре, Р	rint)		0/ 0	10	111	- /1
			Long 5 Hsu.	M.D. 14067		aur	Have .	5.308	Flen B	urmie	MC	21061
	Sta		31. Dete field (Month, Day, Year)	32. Registrar's Sign		מל	J. 00					
	Registr	aſ	MAY 01 199	37 Julia Davi	4401	Mark	مكالله					



State of Maryland / Department of Health and Mental Hygiene 9

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						Cei	rtificate o	f Death		Re	g. No.	•		
	Physic /Medi		1. Decedent's Nama (First, Middla, La Edward	J.	M	00	elin	ski	M	ita of Death onth		3 ⁵ 9 ⁴ 7	3. Tima o	of Death
2	Examiı	ner	4a. Fecility Nama (If not institution, giv THE JOHNS HO	e street and number) PKINS HOSP	ITAL)	BALTIM		TY	4c. County	of Deeth	A	
L	Funeral Director		5. Social Security Number 6. S 210–16–0230 13 Usual Rasidance of Dacedant	7. Age 7. Age 7. Age 7.	(In yrs. last b	irthday) Yrs.	If Under 1 Yes		Min. 8. De Fe	ta of Birth onth, Day b . 10	,1925	9. Birthpi Count Penn	lece (State try) Sylva:	or Foraign nia
	se-f show	ctor	10a. Stata 10b. County Maryland Anne Ar		10c. City, Tov		cation					10	0d. Inside C	City Limits
	23a or 2	Funeral Director	10e. Street and Number 5157 Cedarlea Dri	ve			10f. Zlp Code 207			10	g. Citizan of US.		iry?	
020	d 2 should be filed within 72 hours after deeth with the Maryland thend Mentel Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forcas? 1 ☐ Yas 2 No. If Yas, Giva Yaar or Datas:		i	Was Dacedent of If Yes, specify Ci I□ Yas 2X N		gin? (Specify Y , Puarto Ricen,	es or No- atc.)	Bla	ce - Amarica ck, Whita, a y: Whi	atc.	
Maryland 21215-0020	within 72 ho ene. than *natur ne Medical	Completed	15. Decedant's Ec (Specify only highest gra Elemantary/Secondary (0-12)	College (1-4or 5-	+)	(Giva life. I	dent's Usual Occ kind of work dor DO NOT usa rati	na during most red)		1	6b. Kind of B		lustry	
land 2	should be filed with ind Mentel Hygiene. I marked other than umetic event, the M	To Be Co	17. Fathar's Nama (First, Middla, Last) Walter		gelinsk		tronics	18. Mother	.cian r's Nama <i>(First</i> ilomea	, Middla, M				
	1 end 2 shou Health end M em 27 is merl other trsumeti	-	19a. Informant's Name/Ralationship (Genevieve A. Mog	Type, Print)	19	b. Mellir	ng Addrass (Stra	at and Numbe	r or Rural Rout		City or Town,	, Stata, Zip		
Baltimore,	Peges nent of ant: If it		20e. Mathod of Disposition 1 □ Burial 2XX cramation 3 □ 4 □ Donation 5 □ Othar (Specify	y)	cemete	ery, cran	sition (Nama of natory or other p tan Crei	•	Dat 5-5-9		Oc. Location Alexa			ginia
Bal	permit. Peg Department Important: I any Injury o		21. Signatura of Puneral Service Liber				George 2973 So.	lomons	Island	Rd. I	Edgewa	ter, 1	Md. 2	1037
	Physician /Medical Examiner		23a. Part1. Enter the Jsaasa, or com shock, or heart fellura. List only Immediate Ceusa (Final disease or condition rasulting In death)	a.)	m	onia	ying, such as d	cerdiac or rasp	iratory arra	st,		Approxima intervel Ba Onset and	ta tween Death
ox 68760,	leath certificate be executed ettending physician end d for use es the burial-transit	n/Medical Examiner	Sequantially list conditions, if any, laading to immadiate ceusa. Entar Undarlying Cause (Diseasa or Injury that hitiated events rasulting in death) Last	c	Oue to (or as a			0(6 r	non
.O. Bo	0 0 %	Physician	Part II. Other significant conditions of	ontributing to death but	not resulting	In tha ur	nderlylng ceusa	givan In Part I.	2		acco use co	and the same of th		
rds, P	signed be de	þ	Kenal	tauu	re				20	1 ☐ Ye	autopsy		pably 4	
Records,	has b	Completed								perform	ed?	ava con of c	ailabla prior nplation of deeth?	to causa
Vital		0	25. Wes cesa raferred to madicel					26 Place	of Daath (Che	1 🗆 Yas		1	Yas 2	LNO
>	Physician: this certific ral director,	0	axaminer? 1 ☐ Yas 2 ☐ No	Hospital:	t 2 ER/O	utnation	t 3 DOA	ther-	rsing Homa 5			or /Specifi	d	
of		ä	27. Manner of Death	28e. Dete of Injury	28b.	Tima of			7		v Injury occur		/	
Division	il or Attending Phefer death. Director: After the in by the funeral	Certification:	1 PReturat 5 Pending 2 Accidant invastigation 3 Suicida 6 Could not bedatarmined		y - At home, f	Injury arm, str	M 1	☐ Yas 2☐N	28f. Lo	cation (Straty or Town,	eat and Num t Stete)	ber or Rurai	l Route Nun	n <i>ber</i> ,
	Hospita 24 hours Funeral tely fille	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Madical Exam	ysician: To the best of niner: On tha basis of a and manner state	xamination er	a, daath nd/or inv	occurred et tha vastigation, in my	tima, date end opinion, daati	d plece, and du h occurred et ti	a to tha cau	usa(s) and ma la and place.	anner es ste and due to	etad. the ceusa(s)
	To the To the Comple	Σ	29b. Signature and titla of certifier	hahin	MI	0	R 29c. Lica	ES (000	29	d. Dete signe May	d (Month, L	Day, Year)	37
	Sta	te	30. Name end address of parson who	completed causa of dec	eth (Itam 23a)	(Type,	Print)	John	is A	tpk	ins	Ho	spi,	tal
	Davisto		MAY 0 5 10	97	Davida	1	ndalle						V	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

14587

						Certificate (oi Death		Reg. No.		
Н	Physic	ian	Decedent's Neme (First, Middle, Last	st)				2. Dete of De Month	Dey	Year	3. Time of Death
	/Medi	cal	JAMES O. I				th City Tourn and		1997	-150 11	6:30 pm
Ź.,	Examii	ner	4a. Facility Neme (If not institution, give	e street end number)			4b. City, Town, or L	ocation of Deat	_		
_			CHESAPEAKE MANOR 5. Sociel Security Number 6. S	ex 7 Age	e (In yrs. last birti	hday) If Under 1 Yo	ARNOLD eer if Under 24 Hrs.	8. Dete of Bir			UNDEL
	Funeral Director		1	□M 2□F			eys Hours Min.	(Month, De	ey, Year)		place (State or Foreign otry)
			246-12-4155 Usuel Residence of Decedent		00			NOV. 2	0 1910	NUKI	H CAROLINA
	show d st		10e. Stete 10b. County		10c. City, Town	or Location				1/	0d. Inside City Limits
	Ma Ma	cto	MARYLAND ANNE ARUI	NDEL	ANNAPOI	LIS					1 Yes 2 No
	or 28	Director	10e. Street end Number			10f. Zip Cod	ie		10g. Citizen of \	Whet Coun	itry?
	ath with the Maryla 23a or 28a-f sho		1275 CREEK DRIVE			214	03		US		
	99p	Funerai	11. Meritel Stetus	12. Wes Decedent E Arroad Forces?	Ever In U,S.	13. Wes Decedent	of Hispenic Origin? (Sp Suban, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Rec	e - Americ	
20	be filed within 72 hours efter death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Merried 2 Merried	1 Ves 2 N		1□ Yes 2√□				BLA	
8	ural LEX	d by	3 ☐ Widowed 4 ☐ Divorcad	Yeer or Detes:							
21215-0020	n 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	160.	Decedent's Usuel Oc (Give kind of work do life DO NOT use re	ecupation one during most of work stired)	ing	16b. Kind of B	Jsiness/inc	Justry
712	withi ene. than	m C	Elementary/Secondery (0-12)	College (1-4or 5	+)	OF PROFFE			DETED (חתמחי	N COMPANY
	Hygi Hygi omt,		8th 17. Fether's Neme (First, Middle, Last)	0		111071 100	18. Mother's Nem	e (First, Middle			N COMPANI
au	Mental Mental on arked o	To Be	HERMAN MITCH	HELL			MABEL				
Maryland	SPEE	-	19e. Informent's Neme/Reletionship (7		19b.	Melling Address (Sti	reet end Number or Rur	al Route Numb	er, City or Town,	Stete, Zip	Code)
	offh e		JUDY MITCHELL (WI	FE)	12	275 CREEK	DRIVE ANNA	POLIS,	MD. 2140)3	
re,	- I 5 5		20e. Method of Disposition		20b. Plece of	Disposition (Name o	f plece)	Dete	20c. Location -	City or To	wn, Stete
Ĕ	Peges nent of int: If its iry or o		1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify				N CEMETERY	5/6/97	CROWNSV	ILLE	, MD.
altimore,	parmit. Pege Department of important: If any injury or once.		21. Signeture of Funerei Service Licen	see		22. Name end Ad					
n	a De la co		Jan Hy	2000			E & SONS MO				
	188 10		23a. Pert1. Enter the disease, or com shock, or heart fellure. List only	olications that caused	the deeth. Do n	821 WEST of enter the mode of	ST. ANNAP(dying, such es cardiec	OLIS, M or respiretory e	D. 21401 prest,	T	Approximete
١.	Physician		snock, or near tellure. List only	1						i	Intervel Between Onset end Deeth
а	/Medical		Immediate Cause (Final disease or condition	Carem	mua 9	Colon c	with Kete	retary			3 Months
	Examiner		resulting in deeth)		Due to (or es e c						
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	be executed sician end buriel-transit	cam	Sequentielly list conditions,	D	Due to (or es e c	onsequenca of):					
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OX	n certificate anding physics use es the	Me		d						į	
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r Ö	the d	Physicia	Pert II. Other significant conditions co	ontributing to death bu	t not resulting in	the underlying cause	given in Pert I.				the cause of death?
	thet hed by deta							1	Yes 2 No	3 ☐ Prob	bably 45 Unknown
S	law requires thet the death es been signed by the ette s 2 should be detached for	d by						24a. Wes	en autopsy	24b. We	ere autopsy findings
င္ပ	A req	Completed						perfe	ormed?	cor	allable prior to mpletion of cause deeth?
Ţ	0 5 0	duc						10	Yes 2 No		Yes 2□ No
Vital Records,	iclan: The certificate rector, pag	e C	25. Wes case referred to medical				26. Plece of Deet				1165 20110
	ysician: is certific director.	OB	examiner?	Hospitel:	nt 2 ER/Out	petient 3 DOA	Out A		denca 6 Oth	er (Specifi	v)
10	g Physical Per this	n: T	27. Menner of Deeth	28e. Dete of Injur (Month, Dey	y 28b. Ti	me of 28c. I	njury et Work?		how Injury occur		
UIVISION	ath. r: Aft	atio	1 ☑Naturel 5 ☐ Pending 2 ☐ Accident investigetion		rear) In		1 Yes 2 No				
S	Atte er de ecto by th	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Pleca of Inju	ry - At home, fen	m, street, factory, off	ice		Street end Numb	er or Rura	I Route Number,
5	s eff	Certification:		building, atc	. (upochy)		,	ony or ro	Wi, Olato,		
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	edical	29e. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of	f my knowledge,	deeth occurred et th	e time, dete end piece, ny opinion, deeth occur	end due to the	ceuse(s) end me	enner es st	isted.
	the H in 24 the F	led	one)	end menner ste	ted.	701 Investigetion, in it	ny opinion, deeth occur	red et the time,	dete and pieca,	and age to	(ne ceuse(s)
	To To Teo	Σ	29b. Signeture end title of certifier	1	*		ense number		29d. Dete signe		
			► Colymer My	Attendir	y Doct	or J	021684		5.2	. 7+	
			30. Name and address of person who co	completed cause of de	eth (Item 23e) (T	Type, Print) PASANS	NA MA	11/20			
							, , , , ,		-		
	Sta Registr		31. Dete filed (Month, Dey, Year) MAY 0 5 1997	7 Air	Davidson-A	andell					
			5161 1	(1'							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Day **Physician** Month Year **EUGENE** RICHARD MINNIGH APRIL 1997 /Medical 26 21:55 4a. Facility Name (If not institution, give street end number) 4b City Town or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL & MEDICAL CENTER CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 8. Date of Birth (Month, Day, Year Sep 6, 1 Birthplace (State or Foreign Country)

PA 7. Age (In yrs. lest birthdey) **Funeral** Months Days 74 Yrs. 215-16-4537 Director Usuai Residence of Deceden death with the Meryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Show the Medical Examiner must be notified at MD Allegany Cumberland 1 X Yes 2 □ No Director 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 12 W. Second St. Apt. B 21502 Funeral USA 12. Was Decedent Ever in U,S. Argued Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 end 2 should be filed within 72 hours efter 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 20 3 Widowed 4 Divorced Year or Dates: WW II natural white Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retired Truck Driver PPG 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Mental Gilbert H. Minnigh Regina Mary (Bellaire) 2 traumatic end l 19e. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Health Health Esther L. Minnigh-wife 12 W. Second Street Apt. B; Cumberland, MD 21502 other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove if from State 20b. Piace of Disposition (Neme of 20c. Location - City or Town, State permit. Pages 1 Department of F Important: If ite any Injury or ot once. cemetery, cremetory or other place) Hillcrest Memorial Park 04/29 4 ☐ Donetion 5 ☐ Other (Specify) Cumberland, MD 21. Signature of Funerel Service Licenses 22. Name and Address of Facility
Scarpelli Funeral Home Cumberland, MD 21502 23e. Pert1. Enter the disease, or complice shock, or heart failure. List only one cations that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, e ceuse on each line. Approximete intervei Between Onset and Death **Physician** /Medical Immediete Ceuse (Final . ACUTE MYOCARDIAL INFARCTION 4 DAYS disease or condition resulting in deeth) **Examiner** Due to (or es e consequence of) Examiner 8 Days PNEUMONIA The law requires that the death certificate be executed use es the buriel-tran Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting In deeth) Last and Due to (or es a consequence of): P.O. Box 68760. ettending physician for use es the burie Physician/Medical Due to (or as a consequence of): JULY 1996 d MIXED CA LUNG (SMALL & NON-SMALL CELL) deteched f Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed ! Division of Vital Records. þ 24b. Were autopsy findings eveileble prior to Completed 24a. Was an autopsy peen completion of cause of death? certificate has 1 Tes 2 1 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Manner of Death 1 Netural Date of Injury (Month, Dev Yeer) Certification: 28b. Time of 28d. Describe how injury occurred Affer 1 28c. Injury at Work? 5 Pending Investigation deeth. 1 ☐ Yes 2 ☐ No efter deeth 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) à 4 \(\text{Homicide} \) To the Hospital of within 24 hours el To the Funeral D Medical 112 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and INJe of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL 29, 6 D23371 30. Name and eddress of person who completed cause of death (item 23a) (Type, Print) DR. QAMAR ZAMAN, JOHNSON HEIGHTS MEDICAL BLDG., CUMBERLAND, MD 31. Date filed (Month, Dey, Year) APR 2 9 1997

DHMH 16 Rev 6/95

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR	OINIE OI I		ERTIF					REG. NO	
1. DECEDENT'S NAME (First, Middle, Last) JOSEPHINE M.	MOON							2. DATE OF DEATH MONTH April 24	, 1:
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER	1 YEAR	IF UNDER		7. DATE OF BIRTH	
196-50-9256	1 🗆 M 2 🔀 F	87	YRS.	MONTHS	DAYS	HOURS	MIN.	July 15,1	909
9a. FACILITY NAME (If not institution, give a	treet and number)			9b. CITY	. TOWN	OR LOCATI	ON OF D	EATH	9c. 0

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 the funds after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6874

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	JOSEPHINE M. MOON										2. DATE OF DEATH NONTH DAY YEAR 3. TIME OF DEATH					
	4. SOCIAL SECURITY NUMB	st birthday)	birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.				April 24, 1997				1:15 P. M					
	196-50-9256	5. SEX 6. AGE (In yrs. last		YRS.	MONTHS			MIN.	July	7 15,19	909 PENI		SYLVANIA			
DIRECTOR	9a. FACILITY NAME (If not in:		9b. CITY, TOWN OR LOCATION OF								DUNTY OF DEATH					
	DEVLIN MANO		CUMBERLAND ALLEG								ANY					
	10a. STATE	10c. CIT	10c, CITY, TOWN OR LOCATION							10d. INSIDE CITY LIMITS?						
	MARYLAND		CUMBERLAND						1 X YES 2 NO							
₹	10s. STREET AND NUMBER		101. ZIP CODE						HAT COUNTRY?							
BY FUNERAL	1400 OLDTON	RMED	21502						J.S.A							
	1 Nover Married 2 3 Widowed 4 Divo	NO	IED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify of yea, apecify Cuban, Maxican, Puarto Rican, atc.) t ☐ YES 2 ※ NO Specify:						ea or No — 14. RACE — American Indian, Black, White, atc. Specify: WHITE							
9	15. DEC (Specify only	ECEDENT'S	CEDENT'S USUAL OCCUPATION we kind of work done during most of working					. KIND OF BUS								
E COMPLETED	Elementery/Secondary (0-12) College (1-4 or 5+)					DO NOT use retired.) DMEMAKER					HOME					
	17. FATNER'S NAME (First, Middle, Last) BLAINE LEONARD 18. MOTNER'S NAME (First, Middle, Maiden Surname) NELLIE WILLS															
TO BE	198. INFORMANT'S NAME (Type/Print) ANNA MAE ROBERTSON/DAUGHTER 190. MAILING ADDRESS (Street and Number of Rural Route Number, City or Town, State, Zip Code) 1311 OLDTOWN ROAD, CUMBERLAND, MD 21502															
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of commetter) 20b. PLACE AND DATE OF DISPOSITION (Name of commetter) 20b. PLACE AND DATE OF DISPOSITION (Name of commeter), crematory or other place) DAVIS MEMORIAL CEMETERY DAVIS MEMORIAL CEMETERY															
	21. SIGNATURE OF FUNERA	PARTIE	22. NAME AND ADDRESS OF FACILITY							-						
	Mendy		GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502													
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory erreat, abook, or heert feliure. List only one cause on each lina. IMMEDIATE CAUSE (Final disease or condition resulting in death) a.															
	DUE TO (OR AS A CONSEQUENCE OF): Across Caltaberne in Den															
No.												6 yr				
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF):															
띮	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):															
	resulting in deeth) LAST															
MEDICAL CI	PART II. Other algnifice	nt condition	na contributina to	death but not	resulting	In the ur	derivir	o causa	alven In	Part I	24a. WAS AN	ALITOPSY	246	WERE AUTOPSY FINDINGS		
								PERFORMED?			AVAILABLE PRIOR TO COMPLETION OF CAUSE					
											OF DEATN?					
PHYSICIAN: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO-E-UNCERTAIN															
	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)															
	1 YES 2 TO		HOSPITAL:	☐ ER/Outpetient	3 🗆 DOA	OTHEI 4 Nur		me 5 🗆 F	Reelderice	8 🗆 Oth	er (Specify)					
PH	27. MANNER OF DEATN 1 Natural 5	28b. TIR	NJURY WORK?					28d. DESCRIBE NOW INJURY OCCURED								
BY	2 Accident Investigation						M 1 YES 2 NO				281. LOCATION (Street and Number or Rural Route Number.					
TED	3 Suicide 8 4 Homicide	one, term,						City or Town, State)								
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
	29b. SIGNATURE AND TITLE		29c, LICENSE NUI								SIGNED (Month, Day, Year)					
) BE	<		D/756					65 Egni 25, 198;								
2	30. NAME AND ADDRESS O	#S.	O COMPLETED CAL	SE OF DEATH (IT	EM 27) (Type	e, Print)	-	7 1		- 1	. / 2 -	5	n a	14000		
	30. NAME AND ADDRESS OF PRON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ATTS Office AD 955 Frederick St Cumber 220 A2 21502 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE															
		APR 3 0 1997														

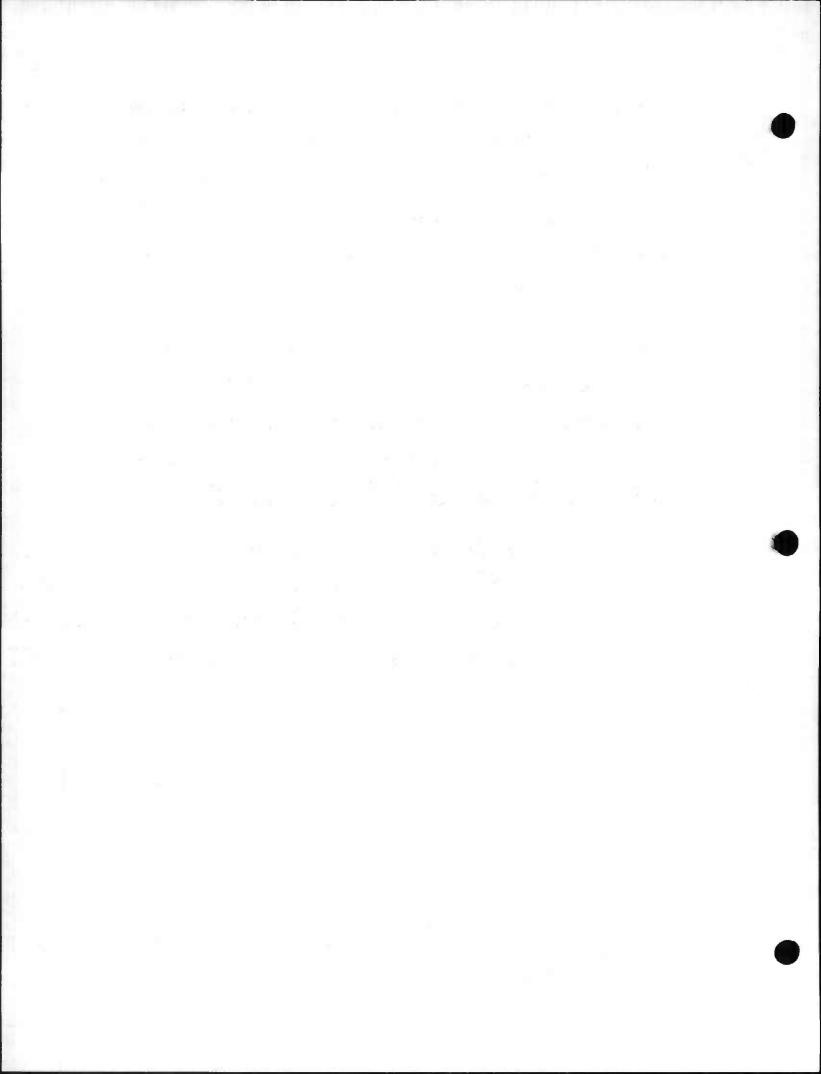
State of Maryland / Department of Health and Mental Hygiene

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							Cel	uncau	e oi	Death		Reg. No.		000		
	Physic /Medi		1. Decedent's Name (RONALD W)	ILLIAM MO	ORAN						2. Date of Do Month April	26, 19	97	3. Time of Death 0050 а.п		
	Exami	ner	As Table Name (Many table to the contract of t													
	Funeral Director		5. Social Security Num 725 14 655	53	7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours											
21215-0020	land ow		Usual Residence of Decadant 10a. State 10b. County 10c. City, Town or Location										1	Od. Inside City Limits		
	Manylan H ehow	to	MD	ALLEGA	NY FROSTBURG							1 Yes 2 □ No				
	h the	Director	10e. Street and Numb		10f. Zip Code						10g. Citizen of What Country?					
	th wit	a	21 FROST	VILLAGE	21532					32		U.S.				
	hours after death with the Manyland turel', or Items 23a or 28a-f ehow at Ecantret must be notified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4	1 X Yes 2 □ No			Vas Deced Yes, spec			(Specify Yes or No erto Rican, etc.)	No- 14. Race - American Indian, Bleck, White, etc. Specify: WHITE					
	22 8 8	etec	(Specify	Decedent's Edi	da completed) (Give			lent's Usua kind of wor	l Occu	pation e during most of i	workina	16b. Kind of E	dustry			
	filed within Hygiene. ther than "rent, the Med	Completed	Elementary/Seconds		College (1-4or 5+)			OO NOT us	e retire	ed) HELPER		BRICKYARD				
Baltimore, Maryland		Be	17. Father's Name (Fit							Name (First, Middle	ma)					
	should be nd Mental marked c	To		JOSEPH 1							LOUISE FOLK					
	0 0 0		19a. Informant's Name								Rural Route Numb			ate, Zip Code)		
	s 1 and f Health Item 27 other tr		EVELYN RA		FE	20b. P	laca of Dispos	sition (Nam	ne of		OSTBURG,			um State		
	0 = 5		1													
	permit. Pa Departmen important: any injury once.		4 Donation 5 Other (Specify) FROSTBURG MEMORIAL PARK 4/28/97 FROSTBURG, MD 21532 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOWERS FUNERAL HOME, P.A.													
			23a. Part 1. Enter the shock, or haart fa	disease, or comp	lications that ca	used the death	Do not ente	W. M	AII AI	N ST., F	ROSTBURG	, MD 215	532	Approximate		
	Physician	Н	shock, or heart fa	allure. List only o	ne cause on as	ch line.			,				1	Interval Between Onset end Death		
7	/Medical Examiner		Immediate Causa (Findisaase or condition rasulting In death)	al	a KE	SPIRA	TOR	7	1	HAILL	IRE		C	20 DAYS		
	D #	al Examiner			A	CUTE	as a conseq	uanca or):	Mo	WIA				DODAY		
	ecute and trans		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that imitated events Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):													
Division of Vital Records, P.O. Bo	certificete be execut iding physician and ise es the bunel-tran												OR YI			
	icete be executed physician and s the buriel-transit	dic	that initiated events resulting In death) Last Due to (or as a consequence of):									10X				
	nding use es	ian/Medical	a CARONIC OBSTRUCTIVE (ULMOWAR) 10 DISEASE										10 (EA)			
	the de	Physicia	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.									ontribute to	the cause of death			
	cian: The law requires th entificate hes been signe- ector, page 2 should be d	by Ph						_			1_	Yes 2□No	3 Prot	Dably 4 Unknow		
		Be Completed									24a. Was	an autopsy ormed?	ava	ere autopsy findings allable prior to mpletion of cause death?		
											10	Yes 2 No	10	Yes 2 No		
			25. Was casa referred examiner?		26. Placa of Death (Check only one)											
	0.0	.T	1 Yes 2 No		12 Inpatient 2 ER/Outpatient 3 DOA Nursing Homa 5 Residence 6 Other (Specify)									/)		
	tending leath. tor: After the fune	Certification:	1 Natural 5	Pending investigation	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No						28d. Describe how Injury occurred					
	al or Attendests efter deat	Sertifi	3 ☐ Sulcide 6 4 ☐ Homicide	determined	28a. Placa o buildin	28a. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Att within 24 hours efter of To the Funeral Direct completely filled in by	edical C	29a. Certifier 10 (Check only one) 2	Certifying Phy Medical Exami	aiclan: To tha b ner: On the bas and manna	sis of examinat	vladge, death ion and/or inv	occurrad a estigation,	it the ti	ime, date and pla opinion, death oc	ca, and due to the courred at the tima,	cause(s) and m date and place,	enner as st and due to	ated. the cause(s)		
	within 2 To the comple	Σ	29b. Signature and title	of cartifier	, /	-		29c	Licen	se number		29d. Date signe	ed (Month, I	Day, Year)		

State Registrar

3 Mes



amended #5, PLK, Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. 578/97 allegany County State of Maryland / Department of Health and Mental Hygiene 1,59 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jessie Catherine McGee 1997 4b. City, Town, or Location of Deeth 9:43PM /Medical 4e. Facility Neme (If not institution, give street and number) 4c. County of Death Examiner 71 Douglas Avenue Lonaconing Allegany | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth | Southly) | Sept. 22, 1898 | Birthplace (State or Information Days | Sept. 22, 1898 | Maryland 5. Social Seprity-Nurse - 996 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 216 - 05 - 572598 Yrs. Director Usual Residence of Decedent death with the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner must be notified at Maryland Allegany Lonaconing ₩ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21539 71 Douglas Avenue USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 X No if Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: SpecifyWhite þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Home 12 other 17. Fether'a Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumame) Be Deperment of Health and Mental: Important: If Item 27 is marked or any injury or other traumatic eve Donald Edward Miller Elizabeth Ann Donald 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 Jessie C. Whiteman -Daughter 14913 Missouri Ave.S.W., Cresaptown, Md. 20b. Place of Disposition (Name of cemetery, crematory or other progreen Cemetery 20e. Method of Disposition May 5, 20c. Location - City or Town, Stete 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 1997 Lonaconing, Md. 21. Signature of Funeral Service Licenaee 22. Name end Address of Facility
Eichhorn-McKenzie Funeral Home anas 21539 Lonaconing, Md. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, about, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death Physician /Medical Immediate Ceuse (Final /Arteriosclerotic heart disease disease or condition resulting in death) uk yrs Examiner Dua to (or es a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed Athors after death.

Euronal Director: After this certificate has been signed by the attending physician and ately filled in by the tuneral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of): Part ii. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown à 24b. Were sutopsy findinga aveilable prior to completion of cause of daath? Be Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Placa of Death (Check only on axaminer? Yes 2□ No Other: 4 Nursing Home ů 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital
within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Msdlcai Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated. Medical 29a. Certifier one) 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) 29c. License number D 09157 May 2 1997 5

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

124 w 3rd st /Cumberland Md 21502

State Registrar 31. Date filed (Month, Day, 1997

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State of Maryland / Department of Health and Mental Hygiene

97 11.502

	Iten	ns:2	28a-f per MEO G-748 6/1	1/97 dh	Cer	tificate of	Death		Reg. No.	01	14092
	Physic	ian	1. Decedent's Name (First, Middle, La	*				2. Date of De		Year	3. Time of Death
	/Medi		HOWARD	EDWARD		Mill	iGAN	MAY	4	1997	0615
	Exami	ner	4a. Facility Name (If not institution, gir	va street and number)			4b. City, Town, or	Location of Deat	h 4c. Count	y of Death	
	Funeral Director		PENINSULA REGION 5. Social Security Number 6. S	IAL MEDICAL CEN Sex 7. Aga (In yrs. 12 M 2□ F 66	TER last birthday) Yrs.	If Under 1 Year Months Days		8 Dete of Bir (Month, De 01/13/	th ly, Year)	OMICO 9. Birthpl Count MARYL	laca (State or Foreign try) _AND
	pud *		Usual Residence of Decedent 10a. State 10b. County	100 Cit	y, Town or Loc	ation					
	h the Meryland r 28a-f show	tor	MARYLAND WICOMIC		FRUITLA					10	od. Insida City Limits 1 X Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip Coda			10g. Citizen of	What Count	try?
	23a unt b	rai	222 SANDCASTLE B	LVD.		21826			U.S.		
21215-0020	72 hours efter death with the Meryland natural, or Items 23s or 28s-1 show deal Examiner pout be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dacedent Ever in U, Armed Forces? 11对Yes 2回No If Yas, Giva Year or Datas 1949—19	If	/as Dacedant of Yes, specify Cut ☐ Yes 2 No	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yas or No o Ricen, etc.)		lace - Americen Indian, Black, White, etc. city: WHITE	
5-0	n 72 hours "natural",	etec	15. Decedent's E	ducetion	16a. Decede	ent's Usual Occu	pation during most of wor	kina	16b. Kind of B	usiness/ind	ustry
121		Completed	Elementary/Sacondary (0-12)	Collega (1-4or 5+)	life. D	O NOT usa retire	ed)	······································	57050		
	tygi Ther		10 17. Father's Name (First, Middle, Last)	FACTO	RY WORKE	18. Mother's Nan	no (Eiret Middle	FIBER		
Maryland	S a S	To Be	CHARLES MAURICE N				MARY PA			iia)	
ary		-	19a. Informant's Name/Relationship (19b. Mailing	Address (Stree	t and Number or Ru			. State. Zip	Code)
Baltimore, M.	ges 1 end 2 it of Health (If item 27 li or other tra		MRS RUBY L MILI 20a. Method of Disposition 128 Burial 2 Cremation 3 C	Removal from Stata	222 S laca of Dispos emetery, cremi	ANDCASTI ition (Name of atory or other pla	E BLVD.	Fruitla Data	and, Md.	2182 - City or Tov	6wn, State
#	artmen ortant: injury		4 □ Donetion 5 □ Other (Special 21. Signature of Funeral Service Ligar		-	ANS CEME		5/6/97	HURLOCK	., MU.	-
	Physician /Medical Examiner	0	Immediata Causa (Final disasse or condition)	plications that ceused the death one cause on each line.	5 11 n. Do not anter	673 SOME r the mode of dyl	VERAL HOMI ERSET AVEI Ing, such as cerdiac	NUE, PR	rrest,	i i	MD. 21853 Approximate Interval Batween Onsat and Death
	LAGITITIEI	er	resulting In death)		r as a consequ						
,00	icete be executed physician end s the buriel-transit	i Examiner	Saquentially list conditions, if any, leading to Immediata ceuse. Enter Underlying Causa (Disease or Injury	b. — Due to (or	r as a consequ	ence of):	5.7			1	
Box 68760,	ding se es	an/Medical	that Initiated events resulting in death) Last	Due to (or							
	the death y the etter sched for u	Physician/	Part II. Other significant conditions of	ontributing to death but not resu	liting in the und	derlylng ceusa gi	ven in Part I.	23b. Did	tobacco uss co	entribute to	the causs of death?
P.0	# D #	Phy				-			Y00 2 X No		ably 4 Unknown
ords,	v requires been sign should be	Completed by							an autopsy med?	com	re autopsy findings ilabla prior to apletion of cause
æ	The law ete has b page 2 s	Dub						10	res 2000		leath?
ital		0	25. Was cesa raferred to medical				26. Place of Dea			1 10	Yas 2000
>	Q 50 Z	To B	examiner? 1⊠Yes 2□ No	Hospital: 1 AInpatient 2□ I	ER/Outpatient	3□ DOA Oti	her:	ome 5 Resid		er (Specify)
			27. Manner of Death 1 □ Natural 5 □ Panding	28a. Date of Injury	28b. Tima of Ound	A 28c. Inju			now injury occur		
Division	Attending or deeth. sctor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be	April 29,1997	0:30		IVac 2 Kalo	hanged se	1f		
Σ	or At ofter of ofter ofter of ofter ofter of ofter ofter ofter of ofter ofter ofter ofter	E .	4 Homicide determined	28e. Place of injury - At hot building, etc. (Specify	me, farm, stree	et, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	per or Rural	Route Number,
	pital purs e pral filled		20a Coddias 45 Codts to Di	home		1.0	· · · · · · · · · · · · · · · · · · ·	same as s			
	To the Mospital or Attend within 24 hours efter deeth To the Funeral Director: . completely filled in by the	edicai	29a. Certifier (Check only one) 1□ Certifying Ph 2⊠Medical Exan	ysician: To the best of my knowniner: On the basis of examination and manner stated.	viedge, death o ion and/or inve	stigation, in my a	ma, data and place, ppinion, daath occur	and due to tha red at the time,	cause(s) and ma data and place,	anner as sta and dua to	ited. the cause(s)
	To the To the Com	×	29b. Signature and title of certifier	^		29c. Licans			29d. Date signe	d (Month, D	lay, Year)
		-	and have	er so.		H 50	049)		5-14	197	
			30. Nama and address of person who can be sometimed of the series of person who can be series of person who can be series of person who can be series of person who can be series of the	completed ceusa of daath (Item	23a) (Type, Pi	rint)). So	disbun	, mo) 2	1801
	Sta	te	31. Date filed (Month, Day, Year)	dit Bulleti Rare Side	ura	- 1 1-04			4		
	Registr	ar	MAY 05 1997 Jul	P							

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

14593

Physician /Medical Examiner

Funeral

Director

the Maryland 28a-f show Examiner must be notified at ŏ 238 death Hems ;

permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth end Mantel Hygiane. Important: If item 27 is marked other than "natural", or hereay Injury or other trauments.

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records.

Division of Vital

To the

Physician /Medical Examiner

The law requiras thet tha death certificete be axecuted and burial physician the 0 2 signed t peen page 2 s has certificata Hospital or Attanding Physician: 24 hours after death. this After after death. in by To the Funeral Dir To the Funeral Dir

1. Decedant's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Death , 1997 Yaar EDWARD MICHAEL NEIDENBACH APRIL 22, 09:36 A.M. 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death MALCOLM GROW MEDICAL CENTER ANDREWS AFB PRINCE GEORGES If Undar 1 Year 8. Date of Birth (Month, Day, Oct 18, 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign t**⊘** M 2□ F Days Hours Michigan 65 579-38-3735 Yrs. 1931 Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d, Inside City Limits District Heights Maryland Prince George's 1 Yas 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6905 Foster Street United States 20747 Funeral 12. Was Dacedant Evar in U,S. Asmed Forcas? 1 M Yas 2 □ No If Yes, Giva Yaar or Datas: 11. Maritai Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Ricen, atc.) 14. Rece - Amarican Indian, Biack, Whita, atc. 1 Never Merried 2 Married 1 ☐ Yas 2 No Specify ģ Specify: 3 Widowed 4 Divorced White Completed 15. Decedant's Education (Specify only highast greda complated) 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondery (0-12) College (1-4or 5+) Electrical Constractor Electrician 4 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be Barbara Schmidt Joseph Neidenbach 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 6905 Foster Street, District Heights, Maryland 20747 Peggy Neidenbach 20b. Place of Disposition (Nama of cematary, crametory or other place) April 28, Date 997 20a. Mathod of Disposition 20c. Location - City or Town, Stata XX Burlai 2 Cremetion 3 Removal from State Cheltenham, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) Maryland Veterans Cemetery 22. Name and Addrass of Facility Lee Funeral Home, Inc. 6633 Old 21. Signature of Funaral Sarvice Licensae Alexandria Ferry Road, Clinton, Md 20735 Locald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardlac or respiratory errest shock, otheart failure. List only one cause on each line. Approximata Intarvai Batween Onset and Death Immediata Ceusa (Final diseasa or condition resulting in daath) a CARDIAC ARREST OF UNKNOWN ETIOLOGY Due to (or es a consequence of) CARDIAC ARRYTHMIA Sequantially list conditions, if any, leeding to immediate ceuse. Enter Underlying Causa (Disease or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): CANCER Physician/Medical Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Wara autopsy findings eveilebla prior to complation of cause of death? Completed 24a. Was an eutopsy 2 No 1 Yes 1 TYas 2 No Be 25. Was case refarred to madical axaminar? 26. Piece of Deeth (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 2 Y Yas 2□ No 1 ☐ Inpatiant 2 XX ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Data of Injury (Month, Dey Year) 28b. Tima of Certification: 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding 1XXVetural 1 ☐ Yas 2 ☐ No

invastigation 2 Accidant 6 Could not be detarmined 3 Suicida 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Spacify) 4 Homicida 29a. Certifian

1 🛣 Certifying Physician: To the best of my knowledge, death occurred at tha time, date end place, and dua to tha cause(s) and menner es steted. and mannar statad.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and place, and dua to the causa(s) 29c. License number

29b. Signetura and sale of certifier

4301060053 MI

29d. Date signed (Month, Dey, Year) APRIL 22, 1997

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

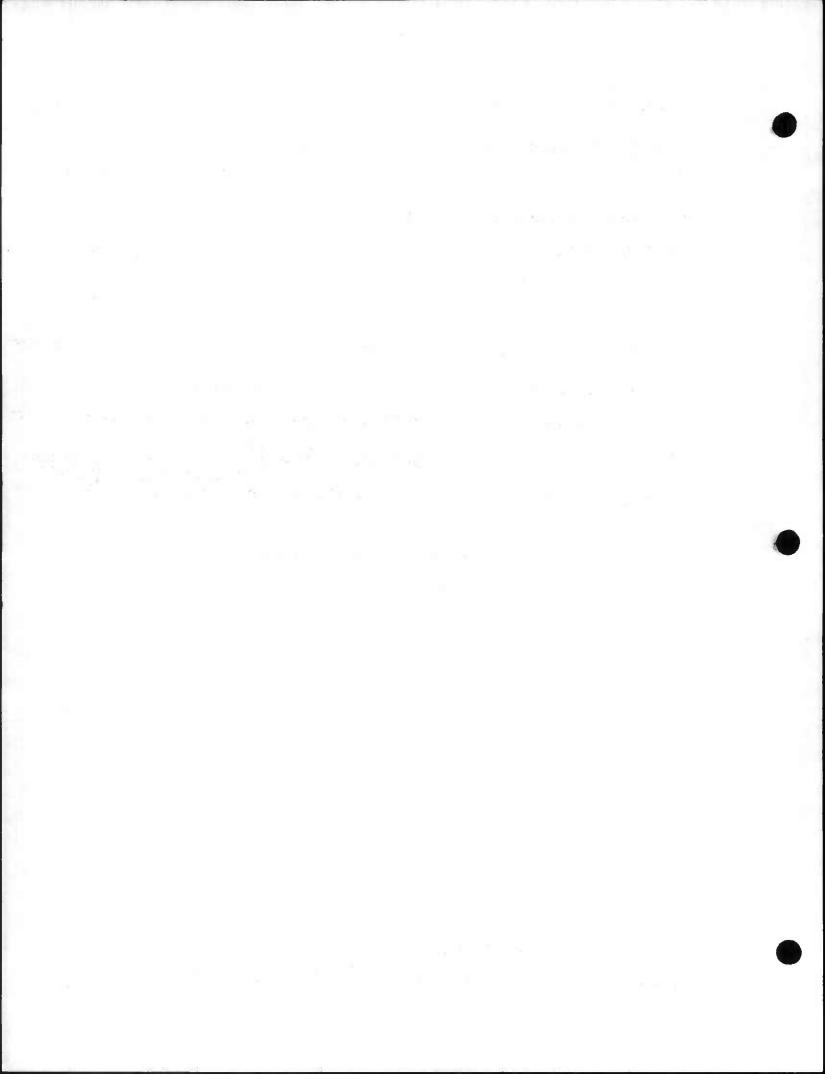
30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)89TH MEDICAL GROUP 1050 W. PERIMETER ROAD/ ZACHARY N. MALACHIAS, CAPT, USAF, MC 1050 W. PERIMETER RD AAFB MD 20762-6600

State Registrar

Medical

31. Date filed (Month, Day, Yaar) APR 3 0

32. Ragistrar's Signature Julia Davidson Revolate



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14594 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 3. Time of Deeth **Physician** Veer JUNE ELIZABETH NEDER APRIL 30 1997 02:05 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY 7. Age (In yrs. last birthday) If Under 1 Yaar If Under 24 Hrs. Months Deys Hours Min. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number **Funeral** 9. Birthpleca (Stata or Foreign 1 M 2 X F Yrs. Director MARYLAND 73 JUNE 2, 1923 219 14 5335 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 10d. Insida City Limits Director 1 ☐ Yes 2XXVo MARYLAND ALLEGANY MT. SAVAGE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 13618 BALD KNOB ROAD, NW U.S. 21545 Funeral 12. Wes Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiana. Important: if item 27 is marked other than "naturely, or the any injury or other traumatic event, are Healtest Examina any injury or other traumatic event, are Healtest Examina any injury or other traumatic event, are Healtest Examina once. 1 Naver Merried 2 Married 1 Yes 2 No Specify: WHITE by Specify: 3 ₩ Widowed 4 Divorced Yaar or Dates. Be Completed 15. Decedent's Education (Specify only highest grede completed) Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumema) LUTHER YEIDER LILLIE WALSH P 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ERIC NEDER/SON 5605 CHILTON LANE, ERIE, PA 16505 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) ST. GEORGE'S EPIS. CEM 5/2/97 MT. SAVAGE, MD 21545 21. Signature of Fugeral Service Lipensee 22. Neme end Address of Fecility SOWERS FUNERAL HOME, P.A. 23e. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intarval Between Onset and Deeth **Physician** Immediete Ceuse (Finel diseesa or condition resulting in deeth) /Medical CONGESTIVE HEART FAILURE **Examiner** Examiner LEIDMYOSARCOMA, LEFT POSTERIOR OLIEST WALL sician and bunal-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieled events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical tha Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown INSULUN DEPENDENT DIABETER MEWTUS þ Completed 24b. Were eutopsy findings eveilebla prior to 24e. Wes an eutopsy ESSENTEM HYPERTENSION completion of cause of deeth? paga 2 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Impatient 2 ER/Outpetient 3 DOA Certification: To 1 Yes 2 IINo 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how Injury occurred 5 Pending investigation 1 Waturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide

1 Dertifying Phyelcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29d. Dete signed (Month, Dev. Year)

21502

Division of Vital or Attending Physician: this in by the funaral Aftar within 24 hours aftar death To the Funeral Director: A filled Hospital complataly 200 10 4268

The law requires that the death cartificate be axecuted

Box 68760.

P.O.

Records,

death with

altimore, Maryland 21215-0020

State Registrar

Medical

31. Dete filed (Month, Day, Year) MAY 02 1997

29a. Certifier

(Check only onel

29b. Signeture and title of certifier

LOVERIA, JOSE, M.D. 938 NATIONAL HIGHWAY CUMBERLAND, MD. Registrer's Signeture

-M.D.

30. Nemeding eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

14595

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Inlury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

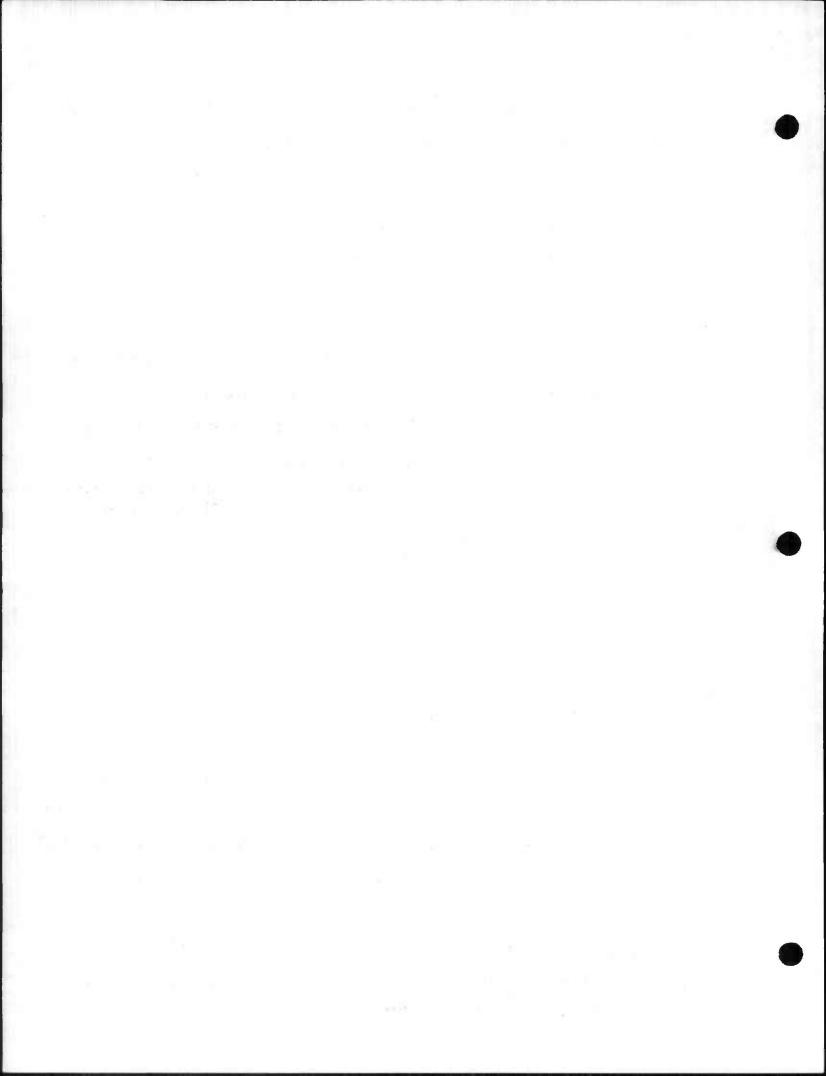
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the build-transit

Division of Vital Records, P.O. Box 68760,

Decedent's Neme (First, Middle			Continious	COIL	Death			Reg. No.		
	e, Last)						2. Dete of Dec	-117		3. Time of Death
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Interstate 8	81 @ 5mi	. marke:	r		HAGE	RST	OWN	WASH	IING	TON
5. Social Security Number	6. Sex	7. Age (In yrs. lest	birthdey) if Under		if Under		9 Date of Birt	h	9. Birtho	olece (State or Foreign
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		don't Supplied III O		1740		1-0 (0-			JSA	and lading
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(Specify only highes	st grade completed)		(Give kind of wo	rk done di	uring most	t of worki	ing			
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Alex Bradley	Navo				EI	Lo	Mass Ta			
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Jo Ann Burger/[Jaughter		20218 Mt	. Ae	tna R	d.	Hagerst			
20e. Method of Disposition			of Disposition (New tery, crematory or o		9)	i	Dete	20c. Location	- City or To	own, Stete
1 Buriel 2 □ Cremetion 4 □ Donetion 5 □ Other (S)	3 ∐Removel from 5	State			•	1	20 07	1./ 2 1 1 2 .		4 110
	.01	or een	lawn Memo				-29-97	Willia	mspo	rT, MU
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23a. Enter the disease, or shock, or heart fillure. List	only one ceuse on e	ech line.	0 1		A					interval Between Onset end Deeth
disease or condition resulting in death)	ө.	Due to (or es	e consequenca of):	vice		JA	pur	4	1	
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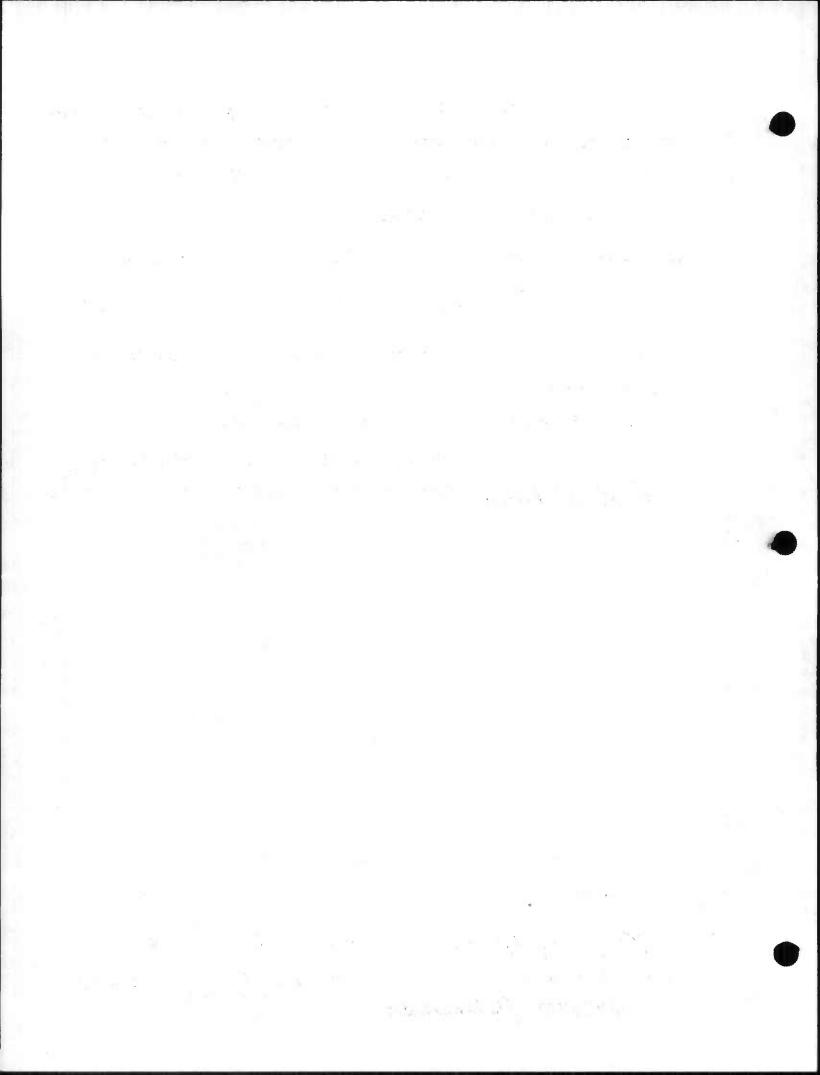
State Registrar



State of Maryland / Department of Health and Mental Hygiene 97 14596

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	Funeral Director			Sex 7. Age 1∭X M 2□ F	e (In yrs. last birthda 70 Yrs	Months Dev		8. Dete of Bir (Month, De OCT . 1	th v Year)		olace (State or Foreign http:) RYLAND						
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Dair	permit, Pag Department Important: I any Injury o		21. Signeture of Funerel Sarvica Lice B. Reutt	22. Name and Address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 21. Name and Address of Facility 21. Name and Address of Facility Approximate													
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	ar death. ector: After by the fune	Certification:	2 Accident Investigation 3 Suicida 6 Could not b 4 Homicide determined	e 28e. Plece of Inju	ry - At home, ferm,	M 1 [Yes 2 No			er or Rurai	l Route Number,						
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	within 24 hours efter death To the Funeral Director: After this completely filled in by the funeral	edical	29a. Certifier (Check only one) 12 Medical Example 19 Medical Example	ysician: To the best of niner: On the basis of and mennar stet	examinetion end/or	eth occurred et the Investigetion, in my	time, dete end plece, e opinion, deeth occurre	end due to the ded et the time, d	euse(s) end me dete and pieca,	enner es sto end due to	ated. the cause(s)						
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,	_ 8	Ve	+ > / hails /	Than	lin	Do	U51466		04	27	97						
			30. Name and address of person who MARTIN H. MAX 31. Date filed (Month, Day, Year)	completed cause of de	eth (Item 23a) (Typ	SIDE DR	, SALISI	BURY	MO	218	0/						
	Sta Registr	te	31. Dete filed (Month Day, Year) APR 2 9 19	3 Registrat	r's Signeture	Ц											

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month John L. Ovington 0335 A.M. APRIL 21, 1997 /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sacred Heart Hospital Cumberland Allegany If Under 24 Hrs. Hours Min. 5. Social Sacurity Number If Under 1 Yaar 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral MOM 2□F Days Yrs. Director 233-38-8620 3-25-1925 Cambridge, OH Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director PA 1 ☐ Yes 2 No Washington Burgettstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ծ Items 23a 196 Purdy Road Funeral 15021 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Dapartment of Heelth and Mentel Hygiane. Important: if item 27 is marked other than "naturel", or then any injury or other traumatic event, the Maples Examples 1 Mayes 2 □ No WWII. If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify: by 3 Widowed 4 Divorcad Specify: White Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Industrial Engineer Weirton Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be John D. Ovington Adelade Lafferty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ellen Ovington (wife)) 196 Purdy Road Burgettstown, PA 15021 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 Pemoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) St. Paul Cemetery 4-24-97 Weirton, WV Service Licensee 21. Signature of Fur 22. Nama and Address of Facility Greco-Hertnick Funeral Home 13219 Main St. Weirton, WV 26062 or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Hospital or Attending Physician: The law requires that the death certificate be assecuted 24 hours efter death.

Funeral Director: After this certificate has been signed by the attending physician end physician end s the burial-trans Sequentially list conditions, if any, leading to Immediata cause. Enter Undarlying Cause (Disease or Injury that Initiated events resulting In death) Last P.O. Box 68760, Physician/Medical Due to (or as a consequence of) esn nse ed by tha a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 | Yes 2 No 3 | Probably 4 | Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) ů 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Spacify) Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital Within 24 hours e To the Funeral E completely

State Registrar

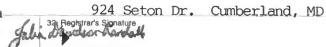
cal

Yriel Velandia 31. Date filed (Month, Day, Year) MAY 0 2 1997

29b. Signature and title of certification

4 Homicide

29a. Certifier



sece-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner as stated.

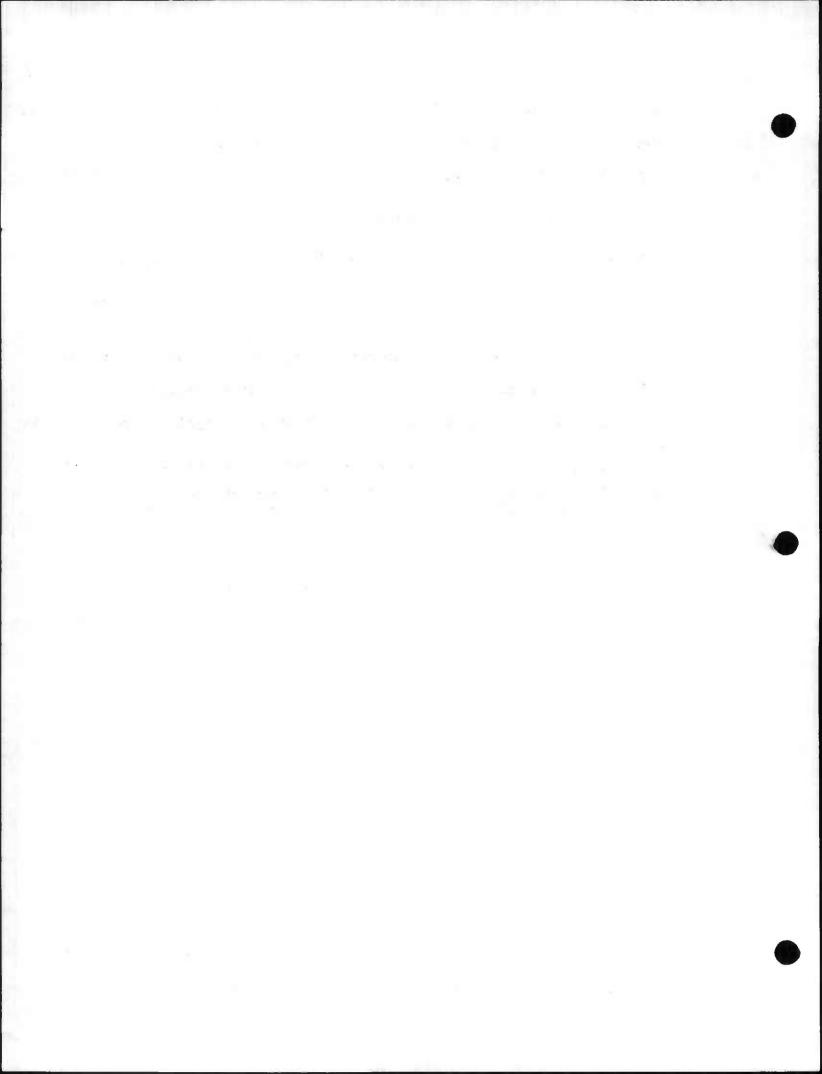
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa numbar

29d. Date signed (Month, Day, Year)

._1997

APRIL



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Death 3. Time of Death

Month

Funeral Director with the Maryland r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at death

Physician

1. Decedent's Neme (First, Middle, Last)

Dolores McPhilomy O'Neill 28, 5:30AM April 1997 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Avalon Manor Nursing Home G HOME Hagerstown Wa

7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth
Months Deys Hours Min. (Month, Dey, Year) Washington 5. Social Security Number Birthpiace (State or Foreign Country) 6 Sex 1 M 2 SF Deys 181-18-0500 Yrs. 75 4/14/1922 Pennsylvania Usuei Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2/2 No Directo W.V. Berkelev Gerrardstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? P.O. Box 244 25420 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Yeer or Detes: 11 Maritei Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Hashin and Mental Hygiena.
Important: If item 27 is marked other than "natural" or hamany injury or other traument. 1 Never Merried 2√Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) instructor dancing 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be William McPhilomy Mary Hughes 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Fintan B. O'Neill P.O.BOx 244 Gerrardstown, WV 25420 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ➡ Buriai 2 ☐ Cremetion 3 ☐ Removei from Stete 4/30/97 Rosedale Cemetery Martinsburg, WV 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fuperei Service Licensee 22. Neme end Address of Fecility Rosedale Funeral Chapel, INC 2060 Rosedale Rd., Mtsbg, WV 25401 uno 23a. Pert . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Onset end Deeth **Physician** /Medical tmmediate Ceuse (Finel months disease or condition resulting in death) Branty Machilles **Examiner** Due to (or es e consequence of): burial-transit be axecuted Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): and P.O. Box 68760. physician s the burial Physician/Medical Due to (or es e consequence of): ding atten ō Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Ariem Anterio nelendis Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an eutopsy performed? Completed peen Cardinargular Dineary uniany Tracer Pulmoners Binean inpution chance orbitalin 1 Yes 2 Ho cartificate Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, I 25. Wes case referred to medical Be 28. Piece of Death (Check only one) examiner?
1 ☐ Yes 2 ☐ No Other: 4 - Nursing Home 5 - Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 27. Menner of Death 28e. Dete of injury (Month, Day Year) 28b. Time of 28c. tnjury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ⊟Naturei 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier Medical tertifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) -corat no 0 (8019 April 28, 1997 30. Name end eddress of person who completed cause of death (item 23a) (Type, Print)

334 Mill Street Hagerstown, Md.

32-Registrar's Signeture

21740

Registrar

State

Dr. V. Datta

APR 2 91997

31. Dete filed (Month, Dey, Year)

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DIRECTOR

FUNERAL

BY

COMPLETED

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CERTIFICATION

PHYSICIAN: MEDICAL

BY -

COMPLETED

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DIRECTOR: After the hours after death w

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has been signed by the attending physician and completely filled in by the funeral Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR

JULIAN

Maryland

11. MARITAL STATUS

10e. STREET AND NUMBER

0 - 12

IMMEDIATE CAUSE (Final

disesse or condition

CAUSE (Disesse or Injury

that initiated events resulting in deeth) LAST

resulting in death)

(Specify only high Elementary/Secondary (0-12)

4. SOCIAL SECURITY NUMBER

088-09-0317

97 14599 1 28.1997 L.B. Amed # 1 Wish Co. April 28 1997 & E STATE OF MARYLAND) DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH LYNWOOD OLIVER April 24, 1997 4:15 P 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Month, Day, Year)
Sept. 26, 1902 94 YRS HOURS Virginia 9a. FACILITY NAME (If not institution, give street and number 96, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Williamsport Nursing Home Williamsport Washington RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Washington Hagerstown 1 YES 2XXNO 10g, CITIZEN OF WHAT COUNTRY? 18703 Preston Road 21742 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Bleck, White, atc. 1 Never Married 2 Married Specify: white 3 Midowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5 +) reality developer developer 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Nicholas B. Oliver Minnie Catherine Cruse 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. June O. Baylor/Daughter Post Office Box 147, Richmond Hill, Georgia 31324 20a. METHOD OF DISPOSITION
1 Of Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Rest Haven Cemetery 4-28-97 Hagerstown, Maryland 4 Donation 6 Disher (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE! 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland anno 23. PART I. Enter the disesses, or complications that caused the deeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximate shock, or heart fellura. Liet only one cause on each line. Interval Between **Onsat and Death** Renal Failure Acute and Chronic months DUE TO (OR AS A CONSEQUENCE OF) And Recent Subdural Hematoma 1 month Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF) PART II. Other significent conditions contributing to death but not recuiting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH?

					1 YES 2 NO
DID TOBACCO USE CON	TRIBUTE TO CAUSE OF DEA	ATH YES	NO D UNCERTA	IN 🖸	
25. WAS CASE REFERRED TO MEDICAL		CE OF DEATH (Chec			
1X YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient	3 DOA 4 X N	6 Other (Specify)		
27. MANNER OF DEATH 1 Netural 5 Pending 2 X Accident Investigation	26a. DATE OF INJURY (Month, Day, Year) March 25, 1997	26b. TIME OF INJURY 8:00A M	26c. INJURY AT WORK? 1 YES ZYNO	28d. DESCRIBE HOW INJURY OCCURED fell at home	
3 Suicide 6 Could not b 4 Homicide determined	28a. PLACE OF INJURY — At h building, atc. (Specify) HIS HOME	ome, farm, street, fa	actory, office	281. LOCATION (Street and Number or Rural City or Town, State) 18703 Preston Road	
29a. CERTIFIER (Check only 1 CERTIFYING PHY	/SICIAN: To the best of my knowledge, d	eath occurred at the	time, date and place, and du	se to the cause(e) and manner as stated.	a nagetstov

2 🕅 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D01062

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Edward W. Ditto, III, M.D. 217 W. Washington St. Hagerstown, Md 31. DATE FILED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE

April 25,1997

A₁₁ (1) (1) (2)

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

					C	ertificate o	f Death		Reg. No.	11	14600	
Physic	ian	Decedent's Neme (First, M						2. Date of Do Month	Day	Year	3. Time of Death	
/Medi	cal	William 4e. Facility Nama (If not instit	Frederick		d		4h Cihi Toum	or Location of Deal	28	97	0259	
Exami	ner						_					
Funeral		Atlantic Gel 5. Sociel Security Number	6. Sax		yrs. last birthde	y) If Undar 1 Yas			nth Wor	ces te	piace (State or Foreign	
Director		178-30-8396 Usuel Residence of Deceder	1 X M 2□ F		Yrs.	Months Dey	s Hours M	Irs. 8. Data of Bi (Month, D. April	ay, Year) 7 , 1940		piace (State or Foreign ntry) nsylvania	
yland		10a. Stata 10b. Co			City, Town or						10d. Inside City Limits	
r 28a-f show	ctor	Pa. Pitt	y of sburgh	Pi	ttsburg	gh,					1 X Yes 2 □ No	
€ 92 E	Dire	10e. Streat and Number	100			10f. Zlp Code			10g. Citizen of	What Cour	ntry?	
ath w	rai	II3 Homestea				15218			US			
d 2 should be filed within 72 hours after death with the Maryland than Mannel Hygiene. 7 Is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Stetus 1 □ Never Merried 2 ☑ 3 □ Widowed 4 □ Divo	Armed Married 1 ☐ Ye If Yes.	ecedent Ever II Forcas? es 2 X No Give Ir Datas:	n U,S. 13	3. Was Decedent of If Yes, specify Cu 1 Yes 2 N		(Specify Yas or Ne erto Rican, etc.)	Specif	ick, White, Wh	can indien, etc. ite	
72 hours natural,	Completed	15. Dece (Specify only h	edent's Education ighest greda complete	ad)	16a. Dec	cedent's Usuel Occ	upetion	vorkina.	16b. Kind of B	usiness/In	dustry	
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permit. Pege Department of Important: If any Injury or once.		21. Signeture of Funeral Ser	vice Licensee			22. Name end Add	lress of Facility			. 9,		
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/Medical Examiner		Immediete Cause (Finei disaasa or condition	A	PULN	IONAR	Y EM	90L1511	1		1	= 15 Mins	
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the attending the death ce	Physician/	Pert II. Other significant con	ditione contributing to	death but not	resulting in the	underlying cause	given in Pert I	23b. Did	tobacco use co	ontribute t	o the cause of death?	
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spital ours neral		29a. Certifier	Ifying Physician: To (the best of my k	knowledge, de	eth occurred et the	time, date and pla	ice, and due to the	ceuse(s) and m	anner es s	stated	
To the Hospital or Attending Physician: within 24 hours after deeth. To the Euneral Director: After this certifica completely filled in by the funeral director.	edical	(Check only 2 Medione)	cal Examiner: On the	basis of exam epper stated.	Inetion end/or	Investigetion, in my	opinion, death oc	courred at the time,	date end plece,	and due to	the cause(s)	
To the Hospital of within 24 hours a To the Funeral D completely filled	×	29b. Signature and title of cer	Mijer	1	7	29c. Lige	nse number	/	29d. Dete signe	od (Mohin,	Day, Year)	
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Registrar

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5-1-97

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last, 2. Dete of Deeth 3. Time of Death **Physician** 26-1997 MARY N. .09 PPRIL /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner MARYLAND ChINTON HOSPITAL PRINCE If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) , Funeral 1□ M 2□XE Months 578-18-2882 75 Yrs. Director Aug. 16,1921 Washington, D.C Usuel Residence of Decedent the Meryland 10e State 10b. County 10c. City, Town or Location 28a-f show 10d. fnside Clty Limits "natural", or items 23s or 28s-f show edical Examiner name be notified at Director Upper Marlboro 1 ☐ Yes 2 No Maryland | Prince George's 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6502 Croom Station Road 20772 U.S.A. Completed by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11 Maritel Status 13. Wes Decedant of Hispenic Orlgin? (Specify Yes or Notif Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indien, Bieck, White, etc. filed within 72 hours efter 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 21215-0020 1 ☐ Yes 2 ☐ No Specify Specify: White 3 ☐ Widowad 4 ☐ Divorced The Medical 15. Dacedent's Education 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry (Specify only highest grede completed) th and Mentel Hygiene.

7 Is marked other than traumatic event, the Menter than traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event, the Menter traumatic event event ev Elementery/Secondary (0-12) Secretary Government Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Peges 1 and 2 should be fill ment of Health and Mentel Hant: If item 27 is marked oth lury or other traumatic even Be William Edward MacFarlane Helen Agnes Thomlinson 19a. Informent's Neme/Relationship (Type, Print)
Sandra O'Donnell (Daughter) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 8632 Valley Drive Waldorf, Maryland 20603 20e. Mathod of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) April 30, 20c. Location - City or Town, Stete 1 XBurlel 2 □ Cremetion 3 □ Removel from State Department of important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) Resurrection Cemetery 1997 Clinton, Maryland 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Lee Funeral Home, INc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735 23a. Pert/ Enter the disaasa, or complications that chused the death shock, or heert feilure. List only one ceuse on each line. Do not enter the mode of dylng, such es cardiec or respiretory errest, Approximete Intervel Between Onset and Deeth **Physician** /Medicai Immediate Causa (Final ardiogenic 12 KM disease or condition resulting in deeth) Examiner Due to (or es a consequence of): Physician/Medical Examiner Interia The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last for use as the burial-tran Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760. Due to (or es e consequence of): Pert fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. signed by the d 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ director, page 2 should be Completed 24b. Were autopsy findings eveileble prior to complation of ceusa of deeth? 24e. Was en eutopsy performed? peen : After this certificata hes 20 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was cese raferred to medical examiner? 26. Piece of Daeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA nours after death.

neral Director: After this y filled in by the funeral di 27. Menner of Deeth Dete of fnjury (Month, Day Year) 28b. Tima of 28d. Describe how Injury occurred 28c. fnjury at Work? 5 Pending investigation 1 Maturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 To the Hospital o within 24 hours af To the Funeral D completely filled i Medical 29e. Certifian 1 Certifying Phyelcfan: To the best of my knowledge, daeth occurred et tha tima, data end plece, end dua to tha ceuse(s) end mannar as stated.

2 Medical Examiner: On tha basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) end manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 345436 30. Neme and eddress of person who complated cause of deeth (Item 23a) (Type, Print) VARKE TEMALE HILLS M 730

32. Ragistrer's Signatura

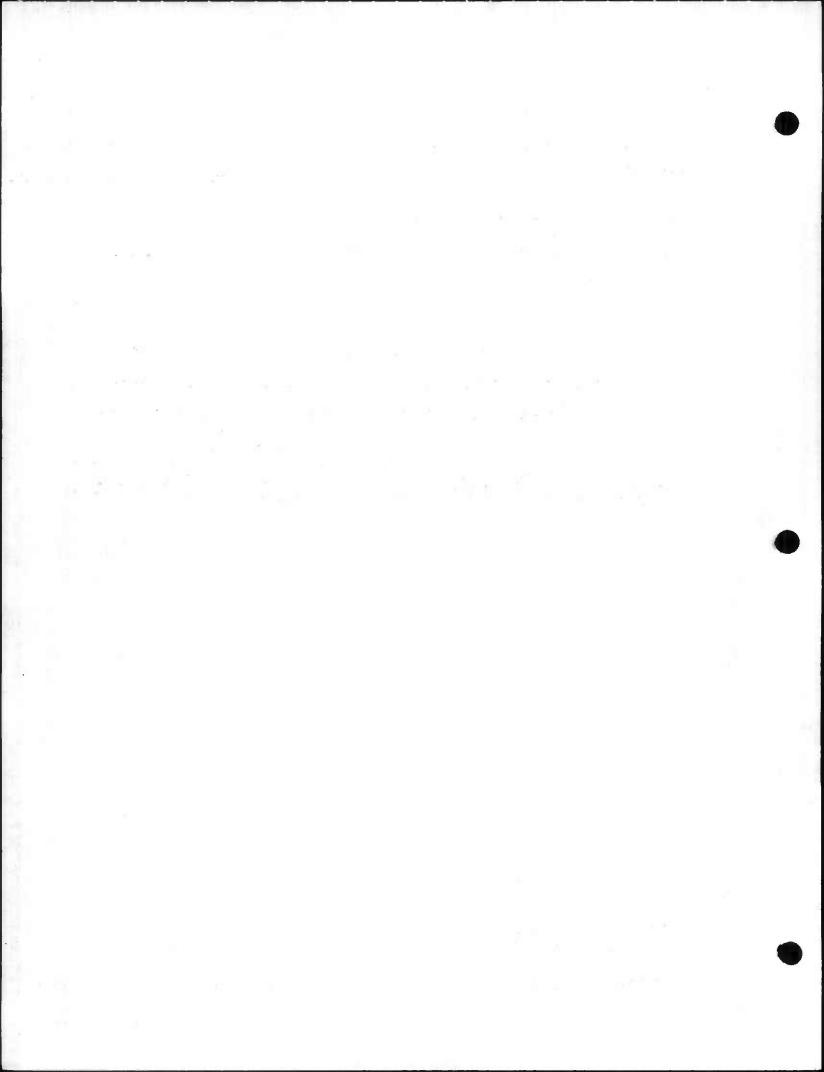
DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Dev. Yaar)

APR 3 0 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 16602 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month Ernest Lee Poland April 28 1997 /Medical 11:00 PM 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death **Examiner** P.O. Box 206 Barton Allegany Hours Min. 8. Date of Birth (Month, Pay, Year) OCT 1921 5. Social Security Number If Under 1 Yaar 6 Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 1⊠M 2□ F Deys 214-16-2917 Yrs. 75 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yas 2 No Allegany Barton 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? P.O. Box 206 21521 United States 12. Wes Decedent Evar In U,S. Armed Forces? 1 □ Yas 2 □ No If Yes, Giva Year or DatesWW I I Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Stetus Race - Amarican Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: þ 3€Widowed 4 □ Divorced Specify: White Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grede completed) Elamentery/Secondery (0-12) College (1-4or 5+) Instrument Man Westvaco Unknown 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Malden Sumema) Be Ernest Poland Ella Lee 2 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Box 199 Ernest Poland Jr./Son Barton, Md. 21521 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Cumberland Crematory 4-29-97 Cumberland, Md. 21. Signature of Funerel Service Liophsee Boal Funeral Home 111 Church St Westernport.Md.

Physician Examiner

The law requires that the death certificate be execu

certificate

or Attanding Physician:

death.

Division of Vital Records, P.O. Box 68760,

Funeral

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Baltimore, Maryland

use es the buriel-transit Physician/Medical ed by the a þ

Examine Completed Be P After this funeral dii Certification: To the Hospital or Attandin within 24 hours after death.
To the Funeral Director: Af completely filled in by the fu

23a. Pert1. Enter the disease, or complications that causad the death. Do not entar the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting in deeth) Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequence of): thet initiated events resulting in deeth) Lest Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contributa to the cause of death? 2 XNo 3 Probably 4 Unknown 1 Yes 24a. Was en autopsy performed? 24b. Were eutopsy findings available prior to completion of causa of deeth? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) 1 Yes 20 No Other: 4 Nursing Home Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Netural Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, daath occurred at the time, data and piece, and due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner steted.

29c. License number

29d. Date signed (Morth, Day, Year)

State Registrar

Medical

FISCUS 31. Deta filed (Month, Dey, Year) APR 30

sture and file of certifi

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

4 T Homicide

29e. Certifle

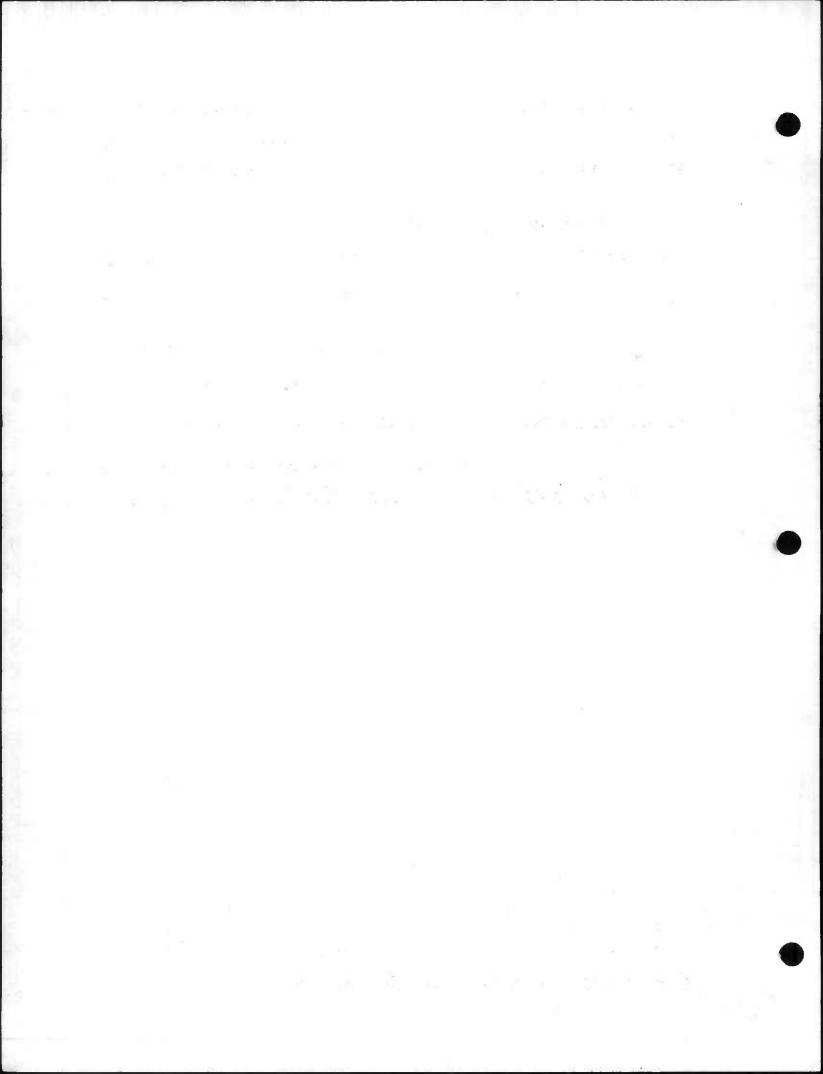
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uneral irector		Security Number -26-7755	6. Sex 1 ☐ M 2	IXE	(In yrs. last		Under 1 Year onths Deys		Min. 8. Dete of (Month, Dec.	Birth Dey, Yeer) 21 1904	9. Birthplece (5 Country) Maryla	State or Fo	
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in "natural", Modical Ex-		15. Deced	ent's Education	4-4-41	16	Se. Decedent's	s Usuel Occup	petion	447	16b. Kind of Business/Industry			
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	1 0	Burlel 2 Cremetion		I from Stete	ceme	tery, cremeto	ry or other ple				- City or Town, St	ete e	
dury		Ponetion 5 Other			Spri			.Garde	en 430	Hebro	n, Md.		
Important: If any injury or 20059.	21. Signe	ture of Funeral Service			1.		me end Addre		al Home				
_ 8 0	Stewart Funeral Home 821 West Rd.Salisbury, Md.21801 23e. Pert1. Enter the dispase, or complications that caused the deeth. Do not enter the mode of dylng, such as cerdlac or respiratory errest, intervel Be intervel Be.												
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Ne funeral Director: After this certificate has been sign pletely filled in by the funeral director, page 2 should be detely filled in by the funeral director. To Be Completed by edical Certification: To Be Completed by	25. Wes constant of the second	ner? Solved Solved	Hospital 28a. 28a. ding stigetion d not be rmined 28e. ring Physician: 1 al Examiner: On end	Dete of Injury (Month, Dey Place of Injury building, etc. To the best of the basis of ed menner state	ry - At home, (Specify) my knowled exemination and	ferm, street, f	28c. Injut Wol 1 Sectory, office	ner: 4 Nursing Ners Ners Ners Ners Ners Ners Ners Ners	Deeth (Check onling Home 5 Received Programme 28d. Described Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Programme 28f. Location City or 1 Processing Pr	y one) sidence 6 Ott se how injury occur of (Street and Numi rown, Stete) se cause(s) end me, dete end plece,	ber or Rurel Route enner es steted, end due to the ce	Number	

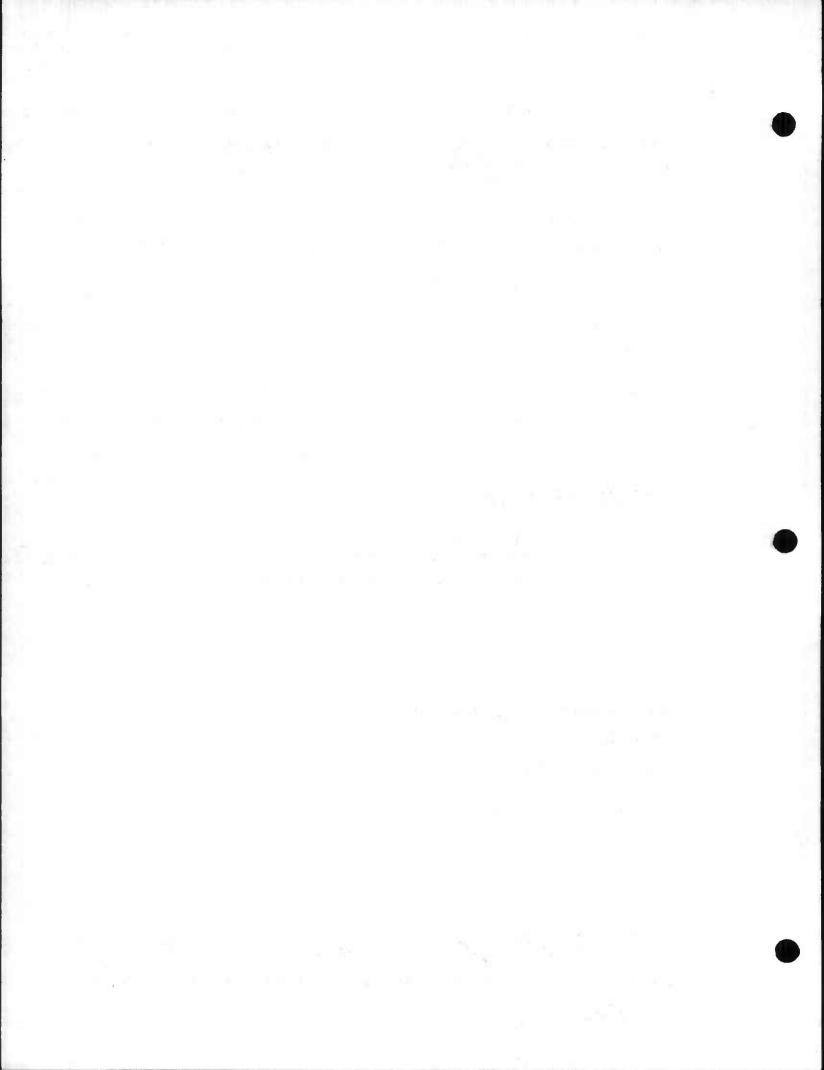
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					State	OT IVI	aryland / L		iment of F ficate of		Mental H	ygien Reg. N	-	7	14604	
	Physic /Medi		Decedent's Nema (First, Mi EUGENE ORVI								2. Dete of D Month			Year	3. Time of Death 2:20 a.m.	
	Examination Funeral Director		4e. Facility Neme (If not institu DEER'S HEAD 5. Sociel Security Number 240-64-1813	CENT 6. S			a (In yrs. lest bir 55			ALISBUR If Under 24 H Hours M	Y MD Irs. 8. Dete of B	irth Jay, Year	C. County	I CO 9. Birthple Countr	ace (Stete or Foreign	
	anyland ahow	٦	Usuei Residenca of Decedent 10e. Steta 10b. Cou		^		10c. City, Tow							10	d. Inside City Limits 1X Yas 2 No	
	h with the M 23a or 28a-f	al Director	MD. WICC 10e. Street end Number 710 HAMMOND S				SALI	SBURY	10f. Zip Code 218()4		10g. C	itizan of V	What Country		
020	72 hours efter death with the Maryland "natural", or items 23a or 28a-f ahow idical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Merried 2 N 3 Widowed 4 Divorce		12. Wes Der Armed F 1 1 Yes If Yes, G Yeer or	orces? 2 N	COACT	If Y	s Decedent of Has, specify Cuba	dispenic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, atc.)	0-	Bled	a - America ck, White, e	tc.	
21215-0020	c • a	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1	hast gr	ducation	"	+)	(Give kin life. DO	nt's Usual Occup id of work done NOT use retired	during most of v d)	working	16b. Kind of Business/Industry U.S. COAST GUA				
Maryland 2	d 2 should be filed within hard Mantal Hygiena. 7 is marked other than traumatic event, train	To Be Co	17. Fether's Neme (First, Midd LESTER POW)						lema (First, Middle EY WALKI	e, Maide				
	t. Pages 1 and the transit of Heeli flam 2 Night of Other Information of the transit of the tran		19e. Informent's Name/Reletic CAROL L. BRINS 20e. Method of Disposition			JGHT	ER 7	10 H	AMMOND S	STREET,	Rurel Routa Num SALISBUI	RY, I	MARYI		21804	
altimore,			1 Burlel 2 Cramation 3 Removel from State 4 Donetion 5 Other (Specify) 21. Signeture of Funaral Servica Licensee 22. Name end Address of Fecility												ARYLAND	
ĕ	Deparing Department of the partment of the par		B. Reco	21804 B. Rett Physics CFSP BOUNDS FUNERAL HOME, 705 E. MAIN ST, SALISBURY, 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate interval Between Interval Bet												
	Physician /Medicai Examiner		Immediate Ceuse (Finel disease or condition resulting in deeth) a. END STAGE RENAL DISEASE Due to (or es e consaquance of):													
	pet usit	Examiner	DIABETES MELLITUS, INSULIN DEPENDENT b. Due to (or es e consequence of):												3 YEARS	
ox 68760,	death certificete be axecuted e attending physician and of for use es the burial-transit	edical	Cause (Disease or Injury that initiated events resulting in daath) Last Due to (or es a consequenca of):													
.O. B	0 0 2	Physician/M	Pert II. Other significant cond	tions o	ontributing to c	leath bu	nt not resulting in	the unda	arlying ceusa giv	an in Pert I.			_		the ceuse of death?	
S, D	signed by	by	CHRONIC OBSTRI	JCTI	VE PULI	MONA	RY DISE	ASE				Yes		3 Probi	ably 4 ☐ Unknown re autopsy findings	
of Vital Record	The law requires that the rate has been signed by the page 2 should be detache	Completed	CORONARY ARTE	RY I	DISEASE						- '	formed?	opsy ⊇ X ∃No	evai com of de	ilable prior to spletion of cause aath?	
Vita	Physician: The rthis certificate rail director, pag	Be	25. Was case raferred to medi exeminer?	cal	Manial				l ou		Daeth (Check only				168 2010	
Division of	Attending Physic death. ector: After this by the funeral di	Certification: To	3 ☐ Suicide 6 ☐ Cou	stigation	28e. Deta (Mor	e of inju	v 28b. 1	Time of njury	28c. Injur Wor M 1 🗆	4 LI Nursing	28d. Describe	how Inju	ury occur	red) Routa Number,	
۵	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in	edical Cer	29e. Certifier 1 Certif	/ing Ph al Exam	yelclan: To the	e best o	f my knowiedge axaminetion en	, deeth od d/or inves	ccurred et tha tir	na, date and ple	eca, end due to the	e ceusa(s) end me	ennar es sta and due to t	ited. the cause(s)	
)	To the within To the compl	64	29b Signature end title of carti	- /	Awa	2	PM	2	29c. Licens	_		29d. D	ate signe	d (Month, D	ley, Year)	
			30. Nama and addrass of personal INJA J. HWANG	, M	D. PO	ST (OFFICE I	BOX 2		LISBURY	, MARYLA	ND	2180	2-201	8	
	Sta Registr	-	31. Dete filed (Month, Day, Yea		7 July	Registre	www.cha	rdell								

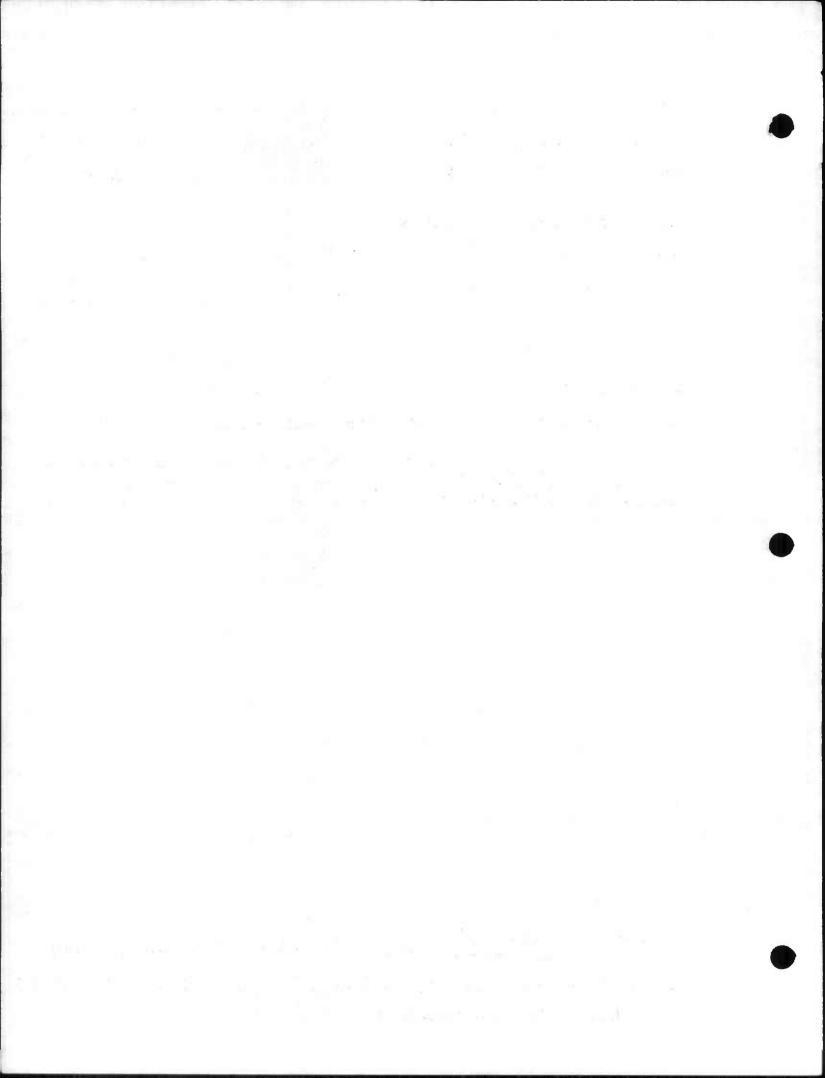
DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

			Ota	e or ivialyia		ertificate of			Reg. No.	37	4605
1	Physic /Medi	cal	1. Decedent's Nama (First, Middla, Last) Richard 4a. Facility Nama (If not institution, give street a	QUI (1	4b. City, Town, or Lo	2. Data of Dea Month	26 /	397 1s	Tima of Death 253pm
•	Examir Funeral Director	ner	Dorches tev Gen 5. Social Sacurity Number 219-42-8371 Usual Rasidance of Dacedant	eral H	8	ay) If Under 1 Year	Cambric	8. Data of Birth (Month, Day MAY 4,	Dor	ches:	(State or Foreign
	Maryland -f show	tor	10a. Stata 10b. County MARYLAND DORCHESTER		City, Town or	Location	W				Inside City Limits
	hours after death with the Maryland turst, or items 23s or 28s-f show	Funeral Director	10e. Street and Number 6521 PINETOP ROAD			10f. Zip Coda 21643			10g. Citizan of V USA		
020	72 hours after death w "natural", or items 23a	by	1 Nevar Married 2 Married 1 H	Decedant Evar in ed Forces? Yas 2 Who is, Giva r or Datas:	U,S. 1	3. Was Decedant of I If Yas, specify Cub 1 ☐ Yas 2 ☑ No		cify Yas or No- Rican, atc.)	Specify	e - Amarican I k, Whita, atc.	ITE
Maryland 21215-0020	within 72 ane. than "naf	Completed	15. Decedent's Education (Specify only highest grade complementary/Secondary (0-12) Collins 1 2	ated) ege (1-4or 5+)	life	cedent's Usual Occup iva kind of work dona a. DO NOT usa retire IDERMIST	pation during most of workind)	ng	16b. Kind of Bu		ny .
land 2		To Be Co	17. Father's Name (First, Middle, Last) RANDOLPH JULIAN PAUL		11111		18. Mothar's Nama	(First, Middle,			
	2 sho end is me	T	19a. Informant's Name/Ralationship (Type, Print ELLEN W. PAUL/WIFE	n		ailing Address (Street					
Baltimore,	Page nent o ant: If		20a. Mathod of Disposition 1 ☑ Burial 2 □ Cramation 3 □ Ramoval 4 □ Donation 5 □ Other (Specify)	from Stata	Place of Dis	sposition (Nama of cramatory or other pla TER MEMOR	се)	Data	20c. Location -	City or Town,	Stata
Balt	permit. Depertrimports eny Inju		21. Signature of Fenaral Sarvice Lipungee	Men		ZELLER FUN 106 MAIN S	ess of Facility ERAL HOME TREET, EAS	P. O.	BOX 20	7, MARYLAN	ND 21631
	Physician /Medical Examiner		Immediata Causa (Final disease, or compilication shock, or haart failura. List only one cause Immediata Causa (Final disease or condition rasulting in death)	lake 1	yocar		Trach Dices		rest,	Inte	proximata arval Between set and Death
Box 68760,	ulres that the death certificete be executed signed by the attending physician end id be detached for use as the bunel-transit	n/Medical Examiner	Sequentially list conditions, if any, leading to immadiata ceusa. Entar Undarlying Cause (Disasas or injury that initiated evants rasulting in daath) Last		or as a con	sequence of):	Diseas	e		ye	20/
P.O. B	the atte	ysicie	Part II. Other significant conditions contributing	to death but not re	sulting in the	a undarfylng ceusa gi	van in Part I.	23b. Dld t	obacco uss con	ntributs to the	cause of death?
Js, P.	res that the signed by	by Physician/N	Adult Onset I	w 03.	esit.			1)0	Yss 2 No		y 4 Unknown
Recor	has been pa 2 should	Completed	Adult Onset 7)iasate	1			24a. Was i	an autopsy med?	avallat	autopsy findings ola prior to etion of causa th?
ital	ian: The	Be Co	25. Was casa rafarred to medical axaminar?				26. Place of Death	1 □ Y	V.C. POIN	1 🗆 Ya	as 2 No
Division of Vital Records,	To the Mospital or Attending Physician: The law requires that the death cert within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use.	ertification: To	27. Mannar of Death 1 Shatural 5 Pending invastigation 2 Accident invastigation 3 Suicida 6 Could not be datamined	Data of Injury (Month, Day Year)	28b. Time Injur homa, farm,	a of 28c. Inju	Yas 2□No	28d. Dascribe h	now injury occurs	red	outa Number,
	e Hospita 24 hours e Funeral	edical C	29a. Cartiflar (Check only one) 1 Cartifying Physician: 1 Medical Examiner: On and	o tha best of my kn tha basis of axamin mannar stated.	nowladga, da nation and/or	ath occurred at tha til invastigation, in my o	ma, data and place, a opinion, daath occurre	and dua to tha dead at tha tima, d	causa(s) and ma data and piace,	nnar as stated and dua to the	t. cause(s)
	To the Comp	M	29b. Signature and title of certifier	1		29c. Licans		1 -	29d. Data signed		
			30. Nama and addrass of person who complated	ceusa oleanth (its	23a) (Tur		28209		PRIL		
			EDMUND J. MAKLAU	QHCIN, 1	10	4 AUROR	EAST., (AMBI	RIDGE,	MA	21613
	Sta Registr		31. Data filed (Month, Day, Year) MAY 1 _ 199/	32. Registrar's Sign	Lear Kan	dall					

DHMH 16 Rev 6/95



DHMH-16 Rev 1/89

physician.	burial-transit permit. Pages 1, 2, 3 should	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should with the State Deot, of Health and Mental Hypiene prior to burial, cremation, or removal.	iner must be notified at once.
certificate be executed within fours after death	is certificate has been signed by the attending physician and completely filled in by the fune rith the State Deot, of Health and Mental Hydiene prior to burial, cremation, or removal.	ked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
VDING PHYSICIAN: The law requires that the death	: After this certificate has been signed by the attent of death with the State Deot. of Health and Mental H	is marked, or item 23 shows any injury, o
TO THE HOSPITAL OR ATTEN	TO THE FUNERAL DIRECTOR: After this of the filed within 72 hours after death with	IMPORTANT: If Item 28 is marked

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Dev D S

31. DATE FILED (Month, Day,

APR 3

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR		STATE OF I	MARYLAND /	NEPARTI	MENT (NE HE	AITH AND	MENTAL H	IVCIENI		9		4 b U
1 - STATE REGISTRAR		OIMIL OI I		ERTIFIC					REG. NO.				
1. DECEDENT'S NAME (First,	Middle, Last)							2. DATE OF	DEATH		1	3. TIME OF DEA	ТН
1	ART	O EP	PERLEY	PR	TOT			Apri	27	7	997	3:06	Ам
4. SOCIAL SECURITY NUME	-C State Health	5. SEX	8. AGE (In yrs. le	at birthday)	IF UNDER 1 Y	YEAR	IF UNDER 24 HRS.	7. DATE OF	,	7		HPLACE (State or I	Foreign
916 20 77	Ch	1 □ M 27 F					OURS MIN.	(Month, Di	ly, Ybar)		Count	(47)	
216-30-77		- 4	85						1912			rginia	
9e. FACILITY NAME (If not in				2.7	b. CITY, TO		LOCATION OF D			9c. COU	NTY OF D		
508 Eastv	iew 1	errace	Apt.	1		Ab	ingdo	n.			Hai	rford	
10a. STATE	10b. COUNTY	1		10c. CITY,	TOWN OR I	LOCATIO	N					10d. INSIDE CIT	Υ
Maryland		Harfor	d				Abin	gdon				1 TYES 2	NO
10e. STREET AND NUMBER						10f. Z	IP CODE			10g. CIT	IZEN OF	WHAT COUNTRY?	
508 E	loetwi	ew Ter	race	Apt.	1		2100	Q			II.S	S.A.	
11. MARITAL STATUS	10,000	12. WAS DECEDEN	T EVER IN II S A	PMED		S DECEN	IDENT OF HISPA		nacify Vac	or No-	-	E — American inc	Han
1 Never Married 2 3 Widowed 4 Divo		FORCES?	YES 2 MAR OR DATES	NO	lf y	res, speci	NO Speci	an, Puerto Rica			Spec	k, White, atc.	
	EDENT'S EDU		16a. Di	ECEDENT'S U	SUAL OCCI	UPATION		16b. KII	ND OF BUS	SINESS/IN		Janoas.	the C4444
(Specify only Elementary/Secondary (6	y highest grade	completed) College (1-4 or 5	(0	live kind of wo	rk done duri	ring most	of working						
Q	p-12)	College (1-4 or 5	*'	Hous	י בייים	fa				Ho	ma		
17. FATHER'S NAME (First, M	Notella (aat)			House	JEWI.		16. MOTHER'S N	ADDE CELLA DALLA	to Maldan		MC		
			777	7		- [ne, Maksen	Surmanne)	TT	. 1 1	
	sey		Epper				Ari			_		all	
19a. INFORMANT'S NAME (1		ham/Da			me :		Number or Aurai	Route Number,	City or Town	n, State, Zi	p Code)		
20a, METHOD OF DISPOSIT	TON						tery, crematory or		20c. LO	CATION -	City or To	own, State	
1 Burial 2 Crematic	on 3 🗆 Rem	oval from State	other p					4/30			-11	arylan	d
21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE) 10	,	22. NA	AME AND	ADDRESS OF F	ACILITY	IIIo	w 0	D		
▶ ///))	HV.	1-07	16-11	1,			rtz F						
111.	mua	even /	100013 1				rrett					OL.	
23. PART I. Enter the d ahock, or h IMMEDIATE CAUSE (Fig	esrt fellure.	complications the List only one ce	at caused the duse or each lin	eath. Do no e.	t enter th	he mode	of dying, su	ch ss cerdled	or reapl	ratory si	rest,		mats Between nd Desth
disesse or condition	_		. 1-	-/	-)		01					>5	
resulting in death)		B	COL S	OUENCE DE		ATEL	1 our	Land	_				7
			(011 710 71 001101										1
Sequentially list condit if sny, leading to imme		b. OUE TO	OR AS A CONSE	EOUENCE OF):	;								
cause. Enter UNDERLY	ING												
CAUSE (Disease or injuthat initiated events	ury	OUE TO	OR AS A CONSE	EOUENCE OF):									
resulting in death) LAS	T												
		d											
PART II. Other significa	ant condition	na contributing to	death but not	resulting in	the unde	erlying (cause given i	n Part I. 24	a. WAS AN		24	b. WERE AUTOPSY	
Can	hors	is of the	a here						PERFOR	ALC: U		AMAILABLE PRIO COMPLETION OF	
		1						_ '	YES 2	MO NO		OF DEATH?	
				-								1 YES 2	NO
25. WAS CASE REFERRED T EXAMINER?	TO MEDICAL	HOSPITAL:		•	OTHER		CE OF DEATH (C	check only one)					
1 TYES 2 NO			☐ ER/Outpetient		OTHER:		5 KRaaldence	6 Other (S	pecify)				
27. MANNER OF DEATH		26a. DATE O		28b. TIME	OF 20	Bc. INJUF		26d. DESCR	IBE HOW I	NJURY O	CCURED		
1 Natural 5	Pending	(Month,	Day, Year)	INJU		1 YE	K? S 2 NO						
2 Accident	Investigation	28e. PLACE	OF INJURY — At h	ome ferm et				281 LOCATI	ON /Street	and Number	v or Bural	Route Number,	
3 Suicide 8 4 Homicide	Could not be determined	building	, etc. (Specify)	come, mini, en	iout, tactory	y, onive			lown, State)		W OF FLORES	ribute Number,	
29a. CERTIFIER	TIEVING BUVA	ICIAN: To the heat	d my knowledge	leath accurat	me obsession	sa deta -	nd plane and 4	in to the amount	al and		etad		
(Check only	ALC: YELL BOOK TO SEE	ER: On the best of										(s) and manner as	stated.
				-076-3	,				, at				- HESSEL
296. SIGNATURE AND TITLE	E OF CERTIFIE	R				1	29c. LICENSE N					D (Month, Day, Yea	
Dans	. D						255	299		1	mil	28,15	5-7

615

32. REGISTRAR'S SIGNATURE

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Per No.

14607

			Certificate of Death Reg. No.														
	Physici	an	Decedent's Nama (First, Middle, Last)										2. Data of Death Month Day Year April 27 1997			3. Tima ot Death	
	/Medi	cal	Lillian Estell Patterson												12:20PM		
7	Examir	ner	4a. Fecility Nama (If not institution, give street end number) Genesis Elder Care Center, Spa Creek								4b. City, Town, or Location of Annapolis			Anne Arundel			
	-		5. Social Security N	Center, Spa Creek 7. Age (In yrs. lest birthday) If Undar 1 Y				1 Year		po11 r 24 Hrs.			_				
н	Funeral Director		5. Social Security Number 6. Sax 1 M :						Months				8. Data of E (Month, I June	15 1908	9. Birti	nplaca (Stata or Foreign	
			Usuei Rasidence o			00	88					Julie .	13 1300	Mai	yland		
Maryland 21215-0020	d within 72 hours after deeth with the Maryland jiene. Than "natural", or ftema 23a or 28a-f show the Medical Examiner must be notified at	To Be Completed by Funeral Director	10a. Stata	_	10c. City, Town or Location									10d. Inside City Limits			
			MD Anne Arundel Annapolis												1 Yas 2 No		
			10e. Street and Number						10f. Zip Code					10g. Citizen o	f What Co	untry?	
	h wit		1856 Milvale Road								21401			Unit	ed St	ates	
	deep		11. Maritai Status		12. V	es Deceden	Ever in U,S.	13. V	13. Was Decedent of Hispenic Origin? (Specify Y It Yas, specify Cuban, Maxican, Puerto Rican,				ecify Yas or N	o- 14. R		ican Indien,	
	or its		1 Nevar Married 2 Married 1 Yas 2 X No					1 ☐ Yas 2 ☒ No Specify:					rican, atc.)		iack, White	i, atc.	
	ral',		3 X Widowed 4 □ Divorced Yaar or Dates:						TO THE ZID NO Specify.					Spec	Wh	ite	
	72 h		15. Decedant's Education (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use rating)										ing	16b. Kind of	Businass/I	ndustry	
121	within 72 ene. than "nat		College (1-40r 5+)											YY			
7	al Hygie other t		unknown 17. Fathar's Nama (First, Middle, Last)						Homemaker 18 Mother's Name				- (Final 84) date	Home			
and	0 5 0		William Russell Patterson									a (First, Middla, Maiden Surnama) unknown) Serman					
e, Maryl	2 should be a end Mental it is marked of aumatic eve						n			101			unknowi				
	d 2 should th end Mer 7 Is marke traumatic		19a. informent's N											ber, City or Tov			
	f Health item 27 other tr		William 20a. Method of Dis	F. Pat	tterso	n_(Son	20b. Pia	1450 ce of Dispos			Poir	it Ro	ad Que			yland 2165	
100	ages it of		1 D Buriai 2	Cramation		ei trom Steta	cen	natary, crem	tary, crematory or other place) Lincoln Crematory 4/2								
Baltimore,	permit. Pages 1 and 2 Department of Health of Important: If item 27 is any Injury or other tra ance.		4 Donation				Ft.									-	
Ba	Depa Impo any l		ND(22.	22. Name end Addrass of Facility ohn M. Taylor Funeral Ho							Home, Inc					
			22a Post Fotos	SANY	>	41-4									polis		
1			23a. Part1. Enter t shock, or has	art failura. Lis	t only ona ca	use on each	lina.	Do not ante	ir tha moo	a or dyr	ng, such a	s cardiac	or raspiratory i	arrest,	1	Approximata Interval Batween Onset and Deeth	
	Physician /Medical Examiner		Immediata Causa	(Finai	$\mathcal D$		4. 4	2	1	6-						1/00.0.	
п			disease or condition resulting in deeth) a. Necure Strokes														
		Je.					Dua to (or a	as a consaq	Jance or):						- 1		
of Vital Records, P.O. Bo	certificate be executed nding physician end use as the burial-transit	Examiner	Sequentially list co	nditions	b. —		Due to for e	s a consequ	uanca ot):		<u> </u>						
			Sequentially list co if any, leading to In causa. Entar Unde Cause (Disaasa or	nmadlata arlying	•		Due to (or es a consequanca ot):										
	ysici	lical	that initiated evants resulting in death)	S	c		Due to (or es e consequence of):										
	ng pl	Completed by Physician/Medical	recently in execut Least												1		
	c & -				d												
	v requires that the death been signed by the ette should be detached for		Part II. Other eignif	lcant conditi	ons contribut	ing to death	but not rasulti	ing in tha un	darlying co	ausa gi	van in Part	I.	23b. Did	tobacco use	ontribute	to the cause of death?	
	hat the d by Jetac		ashin	ation	mountie					10	1 Yee 2 No 3 Probably 4 Unkn						
	signe d be d		July											T 0.45 1	24b. Ware autopsy findings		
	requ									24a. Was an autopsy performed?		e	eveilable prior to completion of cause				
	The lew ate hes t page 2 s	du du													C	death?	
		Medical Certification: To Be Co											10	Yas ZXINO	1	☐ Yas 2☐ No	
	ilcian: Th		25. Was casa rafer axaminar?			28. Place of Death (Check only ona) Hospital: Other: xex.											
	of Attending Pheter death. Director: After this in by the funeral		1 ☐ Yas 2 ☐			1 Inpatient 2 ER/Outpatient 3 DOA #LXNursing Home 5 Residence 6 Other (Specify)											
			1 Neturai	5 Pandi	ng	a. Date of Injury (Month, Day Year) 28b. Time of injury 28c. Injury at Work? M 1 □ Yas 2 □ No								o now injury occurred			
			2 Accident investigation 3 Suicide 6 Could not be datarmined									28f. Location	(Streat and Nu	nber or Ru	ral Route Number,		
<u>S</u>			4 Homicida	datam	imed	building, atc. (Specify)								City or Town, Stete)			
	spita nours neral y fille		29a. Cartifiar (Check only Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s)														
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in		(Check only one)	2 Medical	Examiner: 0	on the basis on the menner s	ot axamination teted.	n and/or Inv	astigation,	in my o	opinion, da	ath occur	red at tha tima	, data and plac	a, and dua	to the cause(s)	
	To the Comp		29b. Signatura and title of commer 29c. License number D11653									29d. Data signed (Month, Day, Year)					
												April 29, 1997					
			30. Nama and addrass of person who completed causa of death (itam 23a) (Type, Print)														
			Peter F. Verkouw, M.D. 2003 Medical Parkway #100 Annapolis, Maryland 21401														
	Sta		31. Data filed (Month, Day, Year) MAY 0 1 1997						-32								
	Registr	all		41 17	1331	0	o pomo largo						- 10				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14608 Certificate of Death 1. Decedent's Nama (First, Middle, Last, 3. Tima of Death 2. Date of Death Month **Physician** Apr. 024 AM Thomas A. 20 /Medical 4e. Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Dorchester General Cambridge Hospital Dorchester If Under 1 Year Months Deys if Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) 5. Sociei Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplaca (Stata or Foreign Country) **Funeral** Deys 108M 2□ F 88 254-28-7426 Usual Rasidance of Decedent Yrs. Aug. 13, 1908 Georgia Director with the Maryland 10a. Stata 10c. City, Town or Location ir than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at 10d. inside City Limits Dorchester 1 ☐ Yes 2 ☑ No Directo Maryland HURLOCK 10e, Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21643 6740 4.5 Bobtown Road Funeral death 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puano Rican, atc.) 12. Wes Decedent Ever in U,S. Armed Forcas? 11. Maritei Stetus 14. Raca - American Indian, Bleck, Whita, atc. hours after 1 Never Merried 2 Married 1 Yas 2 2 No 8 Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Aq If Yes, Give Yaar or Datas: 3 Widowed 4 □ Divorcad Black Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) permit. Pages 1 and 2 should be filed within 72 r Department of Health and Mertal Hydiene. Important: If them 27 is marked other than "nat, any injury or other traumatic event, ma Mardias 16b. Kind of Business/Industry Eiamentary/Secondary (0-12) College (1-4or 5+) Lumber Co. LymberJack 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) Be Rodi ဥ James Mozella BRINSON 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 21613 leasant Day care P.O. Box 219 Campridge, MD. inda 20b. Piaca of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata Dete cemetary, cramatory or other placa) 1 Burlei 2 ☐ Cramation 3 ☐ Ramovel from Steta 4/29/97 Cambridge, Maryland Bethel Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signetura of Funarai Sarvice Licansee 22. Nama and Addrass of Fecility Henry Funeral 23a. Part Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Causa (Final diseese or condition resulting in death) Examiner Dua to (or as a consequence of): Examiner signed by the ettending physician and d be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to Records, P.O. Box 68760, Physician/Medical that initiated events rasulting in death) Lest Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ğ 24b. Wara autopsy findings avellable prior to complation of cause of death? Completed 24a. Was an autopsy certificate has 1 Yes 2 VNo 1 Yas 20 No ne Division of Vital 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 20000 2 1 Yes 1 Dispatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Manner of Death te of Injury onth, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred To the Hospital or Attanding Pi within 24 hours after death. To the Funeral Director: After it completely filled in by the funera Certification: After 1 Naturat 5 Panding invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datampinad 3 ☐ Suicide 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, State) 4 | Homicide 29a. Cartifiar 12 Certifying Physician: To the bast of my knowladga, daath occurred at tha tima, data and placa, and due to the cause(s) and mannar as stated. 2 Medical Examinar: On the basts of examination and/or invastigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) end mannar stated. edicai

State

31. Data filed (Month, Day, Yaa/) APR 28 Registrar

29b. Signature end title of cartifian

Narr,

D.O

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

(Check only one)

Bloomingdale Rd., Federalsburg, MD 21632 32. Begistrar's Signatura

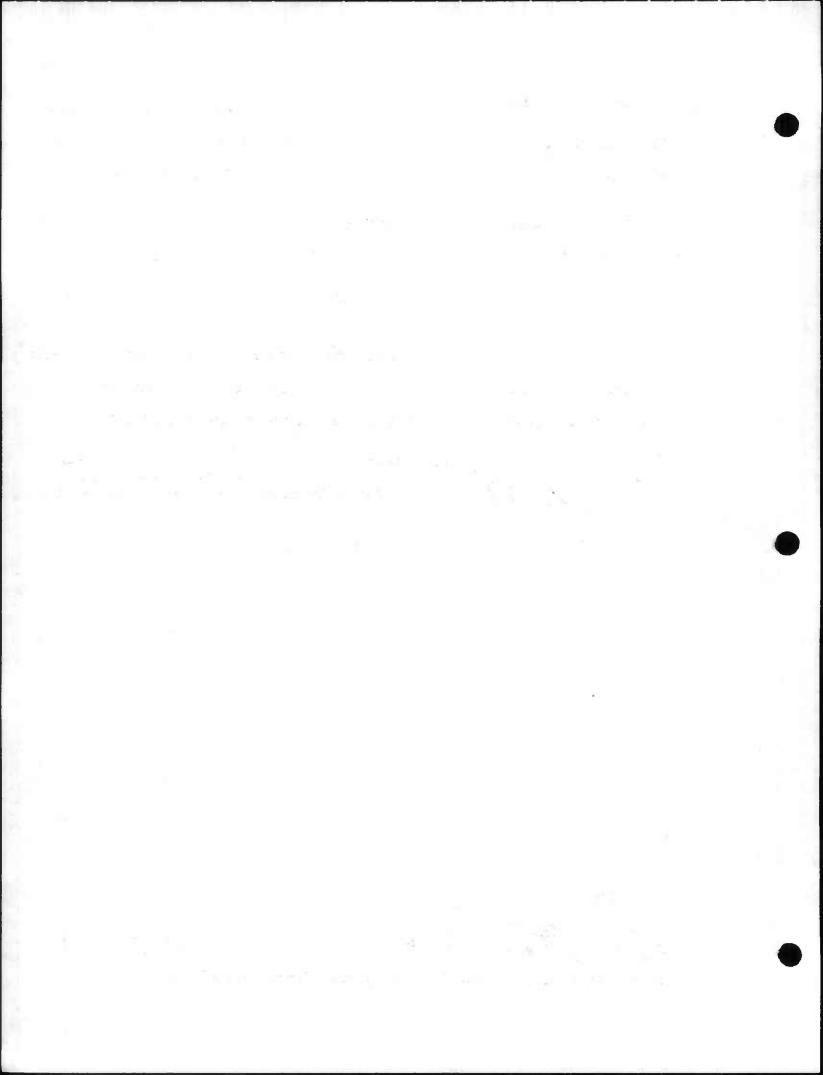
29c. Licensa number

29d. Data signed (Month, Day, Year)

DHMH 16 Bay 6/95

State of Maryland / Department of Health and Mental Hygiene 0 7

					Certific	ate of		Re	g. No.	/	4005
Physici /Medio		Decedent's Neme (First, Middle, La Margaret	Doris	Raucl	h			2. Date of Death Month April	Day	Year 997	3. Time of Death 4:04
Examir		4e. Fecility Name (If not institution, giv 7801 Locris Ct)			4b. City, Town, or L Upper Ma	ocation of Death	4c. County	of Death	eorge's
Funeral Director		5. Social Security Number 6. S		ge (In yrs. lest I 77	Yrs. If Un Monti	der 1 Year hs Days	if Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey, July 8,			ece (State or Foreign) York
show	2	10a. State 10b. County		10c. City, To	wn or Location					10	d. Inside City Limi
23a or 28a-f	Funeral Director	Maryland Prince (10e. Street and Number 7801 Locris Ct.	George's	Upp	er Marli	zip Code 207	72	10	g. Citizen of \		
natural, or items 23s or 28s-f show	by	11. Marital Status 1 Never Merried 2 Married 3 Nover Merried 4 Divorced	12. Was Decedent Armed Forces' 1 ☐ Yes 220 If Yes, Give Year or Dates:	?		cedent of H pecify Cubs	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rec	e - America ck, White, e	tc.
	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12th	de completed) College (1-4or N/A	5+)		work done Tuse retired	during most of work d) n - Budge	t Office		ral G	
ental H ked ott	To Be	17. Father's Name (First, Middle, Last) Frank Sal	lzman				18. Mother's Nam Veron	e (First, Middle, M ica		eever	
0 0 0		19a. Informant's Name/Relationship (Carol McLain (Dat	Type, Print)	19			end Number or Rui	el Route Number,	City or Town,	Stete, Zip (
partment of Health portant: If Item 27 y in ury or other th		20a. Method of Disposition 1 ☐ Burial ② ② Commation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		of Disposition (/ ery, cremetory of Cremato:		_	20,	Oc. Location -		
Department of Important: If its any injury or o		21. Signature of Funeral Service Licen		LCC .	22. Name	end Addres		Lee Fune:	ral Hor	ne, In	nc.
ng physicia s as the bur	n/Medicai Examiner	Immediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. b. c. d.	Due to (or as a	a consequence o		egil.	m	t		1/y
signed by the ettendi be detached for use	by Physician/	Pert II. Other significant conditions co	ntributing to death b	out not resulting	in the underlying	g cause give	en in Part I.				the cause of deat
has been sig	Completed b	Corexa	za.	ler	7 6	leci	-	24e. Was en performe		com	e eutopsy finding leble prior to pletion of cause sath?
certificate he rector, page		25. Was case referred to medical					OR Place of Death	1□ Yes		10	Yes 2□ No
0 O	2 2	examiner?	Hospital:	ent 2 ER/O	outpatient 3 1	DOA Othe		me Residen	ce 6 Othe	er (Specify)	
r daath. ector: Aftar th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 28b.	Time of Injury M	28c. Injury Work	at co	28d. Describe how			
within 24 hours aftar death. To the Funeral Director: Aftar th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, f c. (Specify)	arm, stroot, facto	ory, office		28f. Location (Stre City or Town,		er or Rural	Route Number,
within 24 hours a To the Funeral C completely filled	edical	29a. Certifier (Check only one) Check only one)	sician: To the best of iner: On the basis of and manner sta	examination at	e, death occurre	ed et the tim on, In my op	ne, dete end plece, pinion, death occurr	and due to the ceu ed et the time, dat	ise(s) and me e and place, e	nner es sta and due to t	ted. he cause(s)
To the comp		29b. Signeture and title of certifler	con	Te 1	2	9c. License	225/	290	d. Date signed	(Month, De	ey, Year)
		30. Name and eddress of person who c Rene Grace M	ompleted cause of d	eath (Item 23a) 131 Pis	(Type, Print) Cataway	Road	Clinton,	MD 2073	5-2509		
Stat	е	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	P						

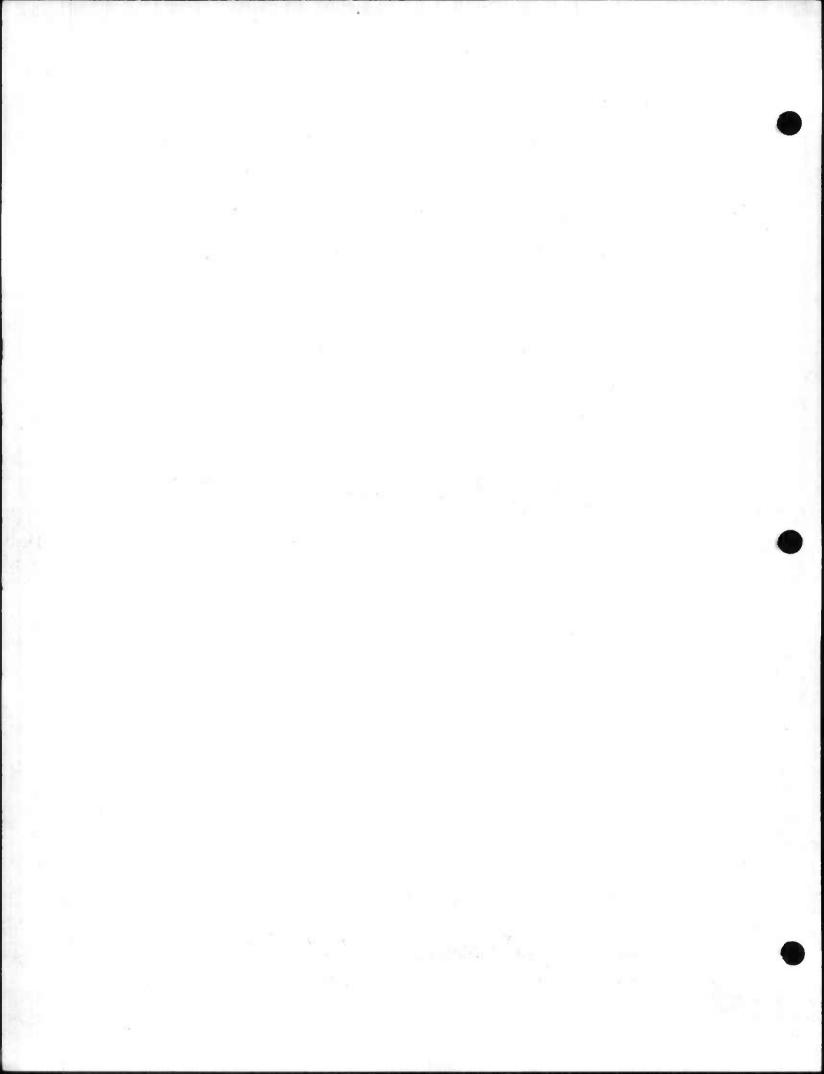


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day 1997 **Physician** Month JAMES PHILIP ROOK, SR. APRIL 26, 3:53 P.M /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** GARRETT COUNTY MEMORIAL HOSPITAL OAKLAND GARRETT 6. Sex 1X M 2□ F 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) **Funeral** 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (State or Foreign Deys Hours Yrs. Director 215-20-5626 69 NOV. 28, 1927 MARYLAND Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10e State 10b County 10c. City, Town or Location 10d. inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at GARRETT Funeral Director MD OAKLAND 1 X Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 631 S. THIRD STREET 21550 USA Items 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispenic OrlgIn? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 21215-0020 ò 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education
(Specify only highest grede completed) 16a, Decedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) INSURANCE AGENT INSURANCE Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: If flem 27 is merked other any injury or other traumatic event pages. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be HAROLD EUGENE ROOK **EDWANA** PEDDICORD 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BEVERLY J. ROOK 631 S. THIRD ST. OAKLAND, MD 21550 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 🛣 Cremetion 3 ☐ Removel from Stete OMEGA CREMATORY 5/1/97 MORGANTOWN, WV 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility P.O. BOX 243 M00167 DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dyling, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Respirator Examiner Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical Due to (or es e consequence of) signed by the at d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à Completed 24b. Were autopsy findings evelleble prior to 24e. Wes an autopsy performed? completion of cause of deeth? cartificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA After this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of Certification: 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Neturel death. 1 Yes 2 No 2 Accident d in by the 3 Suicide 6 ☐ Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) aftar 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di complately filled in Descripting Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29e. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 PAUL DANIEL MILLER, D.O. 2225 G.W.PLAZA OAKLAND, MARYLAND 21550

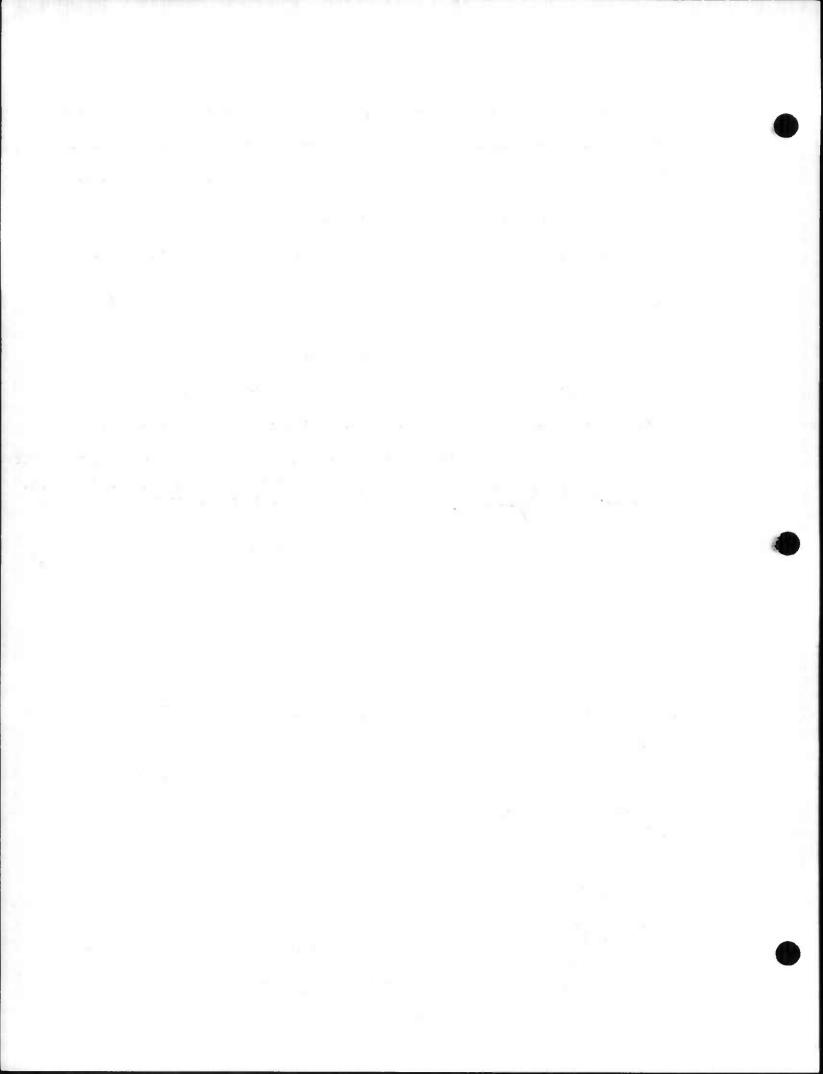
State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature ili Soucher Radall



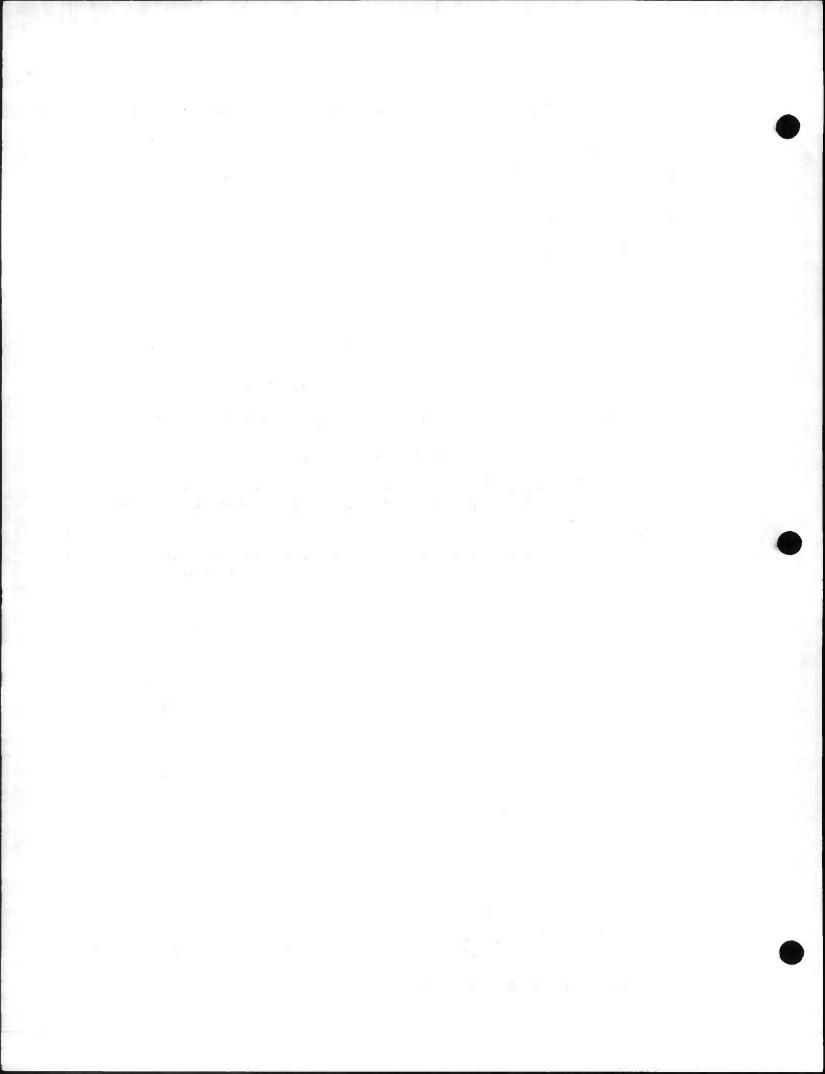
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Dep	ertificate of D		, ,	g. No.	7	14611
ı	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Deatl Month	Day	Year	3. Time of Death
	/Medic		Gladys Andrews Rus	sell		April		97	1:45AM
	Examir		4e. Facility Name (If not institution, give street and number)		. City, Town, or Loc		4c. County		113111
			Anne Arundel Medical Center		Annapolis		Anne	Aru	nde1
П	Funerai		Social Security Number Sex Age (In yrs. last birthda)	y) If Under 1 Year Months Days	Annapolis If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State or Foreign
Н	Director		019-10-3986 1□ M 2XF 92 Yrs.	Michial Days	TIOUTS WIIIT.	Nov 26			chusetts
	p ,		Usual Residence of Decedent						
	aryla shov	<u>.</u>	10a. State 10b. County 10c. City, Town or I					10	Od. Inside City Limits
	S M	Director	MD Anne Arundel	Annapolis					1 ☐ Yes 2FTNo
	\$ 0 th	E C	10e. Street and Number	10f. Zip Code		10	g. Citizen of W		
	23a		612 Wayward Drive	214	401		United	. Sta	tes
	em.	Funeral	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spec	cify Yes or No-		- America	
20	within 72 hours after death with the Maryland ilene. Than "natural", or fems 23a or 28a-f show the Madical Examine must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	_	Specify:	,			
00	iral',	d by	3 XXVidowed 4 ☐ Divorced Year or Dates:	XX			Specify.	Whi	te
21215-0020		Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupati re kind of work done du	ion ring most of workin	g 1	6b. Kind of Bu	siness/Ind	Justry
121	within ene.	Пр	Elementery/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)					
			12	Homemake			Hom		
anc	tal H d ott	Be	17. Father's Neme (First, Middle, Last)	1	8. Mother's Neme	(First, Middle, N	faiden Sumame))	
7	should be and Mental marked of umatic eve	T _o	Wilbur Andrews			s Holme			
Maryland	01 (0 (0) (0)			iling Address (Street en	d Number or Rural	Route Number,	City or Town,	Stete, Zip	Code)
				Wayward Di		*	Marylan		
altimore,	of H		20e. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 20b. Plece of Disposition cemetery, or	position (Neme of ematory or other place)		Date 2	20c. Location - 0	City or To	wn, State
Ë	Pag men ant: ury		4 □ Donation 5 □ Other (Specify) Vine La	ke Cemetery					assachusett
Ball	pemit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.	İ	21. Signeture of Funeral Servica Lipsipsee	22. Name and Address	of Fecility John	M. Tayl	or Fune	ral	Home, Inc.
		_	(Inalla) Vayla	4/ Duke of	Gloucest	er St.	Annapol	1S,	MD 21401
			23a. Pert. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying,	such as cardiac or	respiretory arre	st,		Approximate Interval Between Onset and Deeth
)	Physician /Medical		Immediate Cause (Finel disease or condition	0 10000	- fri. O.	110)			
	Examiner		disease or condition resulting in death)	- rear	ryaner			-	> days
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68760,	ficate be executed physician and is the bural-transit		cause. Enter Underlying Cause (Disease or Injury thet initiated events					-	
587		edicai	resulting In death) Last Due to (or es e conse	equenca of):					
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Δ.	that the ed by detac	F	strutus post resection of ganon	enous b	one	1 🗆 Ye	s 2 No	3 Prob	bably 4 Unknown
Vital Records,	8 5 8	d by	incurcuated femoral her			045 1445-55	тТ	24h Wa	ere autopsy findings
Ö	requires been sign should be	Completed	inculculo femoral nei	nia		24a. Wes an perform	ned?	ava	ailable prior to
Sec	9 0 C	d							deeth?
E	T age					1 ☐ Ye	s 2 No	1	Yes 2□ No
<u> </u>	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?		26. Piece of Deeth	(Check only one	9)		
o	Physic this c	2	1 ☐ Yes 2 ☐ No Hospitel: Nonpatient 2 ☐ ER/Outpatient		4 LI Nursing Horr				')
	ng P	9	27. Manner of Deeth 1 ☑Natural 5 ☐ Pending (Month, Dey Year) 28b. Time (Month, Dey Year)		it 2	8d. Describe ho	w Injury occurre	d	
Sio	Attending or death.	cati	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Ye	s 2 No				
Division	or Att after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, offica	2	Bf. Location (Str. City or Town,		r or Rurai	i Route Number,
۵	is af								
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	29a. Certifier (Check only (Check only 2 ☐ Medical Examiner: On the basis of examination and/or i	th occurred at the time,	, dete end place, ar	nd due to the ca	use(s) and mar	ner as sta	ated.
	the hin 2 the h	Ned Per	and manner stated.						
	or vit	Σ	29b. Signatura/syts titld gr conflier	29c. License r	number	29	d. Date signed	(Month, L	Jay, Year)
			Mulle X	D44	161		4/3	50/9	
		1	30 Name and address of person and completed cause of death (Item 23a) (Type	Print)		1	in I	•	1
			Patricia Czapp, MD 200 Irvma	n You Ewa	y Ar	mapoli	5, MI	2	1401
	Sta	_	Patricia Czapp, MD 200 IV mai. 31. Dete filed (Month, Day, Year) MAY 0 2 1997 MAY 0 2 1997 MAY 0 2 1997	1 00	U	*			
	Registr	ar	MAY 02 1997 Julia Davidson-Ro	ndebes					
DH	MH 15 Bey 5/95		<i>C</i>						



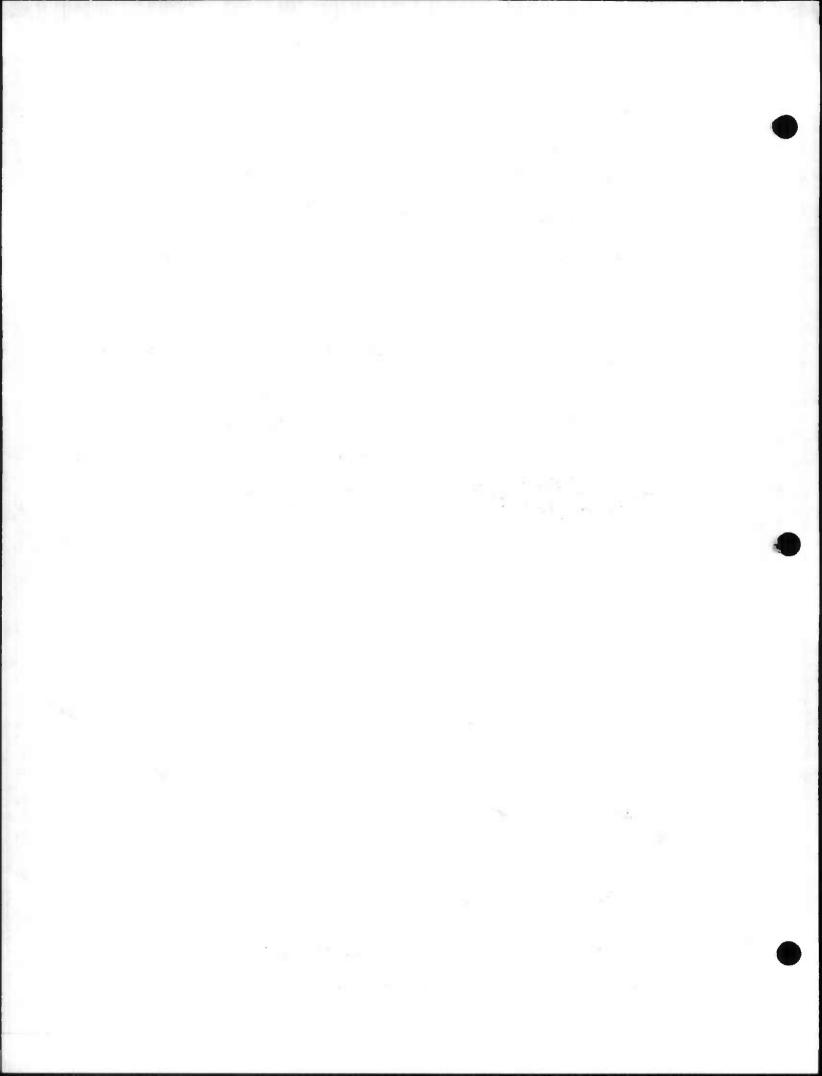
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Physician BECKMAN KATHRYN ROSENMARKLE April 24, 1997 1:00 am /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 5. Social Sacurity Number 7. Age (In vrs. last birthday) Birthpiece (Stete or Foraign Country) **Funeral** Days 1 ☐ M 2 🛣 F Months Director 219-14-5220 73 Aug.13, 1923 Maryland Usuai Rasidanca of Dacadant the Maryland 10b. County 10c. City. Town or Location 28a-f show 10d. Insida City Limits Director the Medical Examiner must be notified Maryland Allegany 1 X Yas 2 No Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? with t 23a or 10 N. Liberty Street 21502 USA death v Funeral Items 11. Maritai Status 12. Was Dacedant Evar in U.S. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indian. Armed Forcas? 1 ☐ Yas 2 No Black, White, atc. filed within 72 hours efter Or J 1 Nevar Married 2 Marriad altimore, Maryland 21215-0020 1 ☐ Yas 2 K No Specify: Specify: White by 3 Widowed 4 Divorced natural'. Year or Dates: Be Completed 18a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education
(Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Coilege (1-4or 5+) Elamantery/Secondary (0-12) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Peges 1 and 2 should be nent of Health end Mental is marked E. Maurice Beckman Mary Zirkle 2 19a. Informant's Name/Raiationship (Type, Print) 19b. Meiling Addrass (Street and Numbar or Rural Routa Number, City or Town, State, Zip Coda) permit. Peges 1 and 2: Department of Health er important: If Item 27 is any injury or other trace Mary Shoemaker 230 S. First Street LaVale, MD 21502 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Buriai 2 ☐ Cramation 3 ☐ Ramovai from Stata Sunset Memorial Park May 2, 1997 Cumberland, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Hafer Chapel of the Hills Mortuary 1301 National Hwy. LaVale, MD 21502 Do not anter the mode of dying, such es cardiac or respiratory arrast, Approximata one cause o Interval Between Onset and Death **Physician** /Medical Immadieta Cause (Final disaese or condition rasulting in deeth) a Hypertrophic cardiomyopathy with acute congestive 10 days Examiner Dua to (or es e consequance of): heart failure Examiner sician and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laeding to immediate causa. Enter Undarlying Causa (Disaase or injury that Initiated avents rasulting In deeth) Last Due to (or es e consaguance of): P.O. Box 68760, Physician/Medical the the Dua to (or as a consaquanca of): 98 USB ed by the ed Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been signed i should be det Records, þ 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24a. Was en eutopsy page 2 1 Yas 2 No certificate 1 ☐ Yas 2 ☐ No of Vital Hospital or Attanding Physician: director. Be 25. Wes casa referred to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: 2 1 Yas 2 No Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Minpatiant 2 ER/Outpatient 3 DOA this funeral Certification: 27. Mennar of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division 1 Naturel 5 Pending Invastigation s after death. 1 ☐ Yas 2 ☐ No 2 Accidan in by the 6 Could not be detarmined 3 Suicida 28a. Piece of injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 Homicida 24 hours a 29a. Certifier cai 🔯 Certifying Physician: To tha bast of my knowladga, daath occurred at tha tima, data and place, and dua to the causa(s) and mannar as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and menter stated. To the within 2 To the 29b. Signatura and titia of bartiflar 29c. Licansa number 29d. Data signed (Month, Day, Year) D 35481 April 34 1997 30. Name and addrass of person who completed causa of death (Item 23e) (Type, Print) DK) Dr. Mark Sagin, Memorial Hospital, Cumberland, MD 21502 31. Dete filed Mon Ragistrar's Signature State a Booder Revolate Registrar



State of Maryland / Department of Health and Mental Hygiene

					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Ce	rtificate d	of L	Death		Reg. No.	31	14613
	Physic	ion	1. Decedent's Name (First, Middle, Li	ist)						2. Dete of Dee		Year	3. Time of Deeth
	Physic /Medi Exami	cal	JUANITA MA 4e. Fecility Neme (If not institution, gi			ROBB	INS	4	b. City, Town, or L	April 2	9, 199		4:50 P. M
1			MEMORIAL HOSPITAL					C	UMBERLAN	ID	ALI	LEGAN	Y
į.	Funeral Director		5. Social Security Number 6.		ge (In yrs. les 96	Yrs.	If Under 1 You Months De	-	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, De)	h v. Year)	-	plece (State or Foreign ntry) W.VA.
	Puel Puel		10e. State 10b. County		10c. City, T	own or Lo	ocation						10d. Inside City Limits
	Mary	io to	MARYLAND ALLEG	ANY	CUI	MBERL	AND						1√2 Yes 2 □ No
	r 28s	Directo	10e. Street end Number				10f. Zip Coo	de			10g. Citizen of	f Whet Cou	ntry?
	h with		OLDTOWNE MANOR	APT#A			215	502			II C	A	
	deat	Funerai	11. Marital Stetus	12. Wes Decedent Armed Forces	Ever in U,S.	13.			spenic Orlgin? (Sp n, Mexican, Puerto	pecify Yes or No-	U . S .	aca - Ameri	
Maryland 21215-0020	hours after death with the Maryland urat, or items 23s or 28s-f show at Exerciset must be indified at	by	1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 V			1 Yes 2√		Specify:	Hican, etc.)	Spec	eck, White,	HITE
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92			12 17. Fether's Neme (First, Middle, Last	3		- 110	USE KEE	SFE		a /Final Middle		E KEEI	PER
an	S is o >	Be c							18. Mother's Nem			me)	
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	d 2 7 Is		JUANITA WRIGHT	D.A.					MP ROAD				
re,	- HE E		20e. Method of Disposition		20b. Plac	e of Dispo	sition (Neme of	f	T	Dete	20c. Location		
Baltimore,	it. Page rtment o rtant: If njury or		1 M Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Control of Functors Service Lies			REST	CEMETE	RY	MAY 2 1	997	UMBERL	AND M	ARYLAND
Ba	permit. F Departm Importar any Injur		21. Signeture of Funerat Service Line	11 -1	_	ME	2. Name end Ad RRITT-A	DAI	MS FIINER	AL HOME			
			23e. Pert if Enter the disease, or con shock, or heart feilure. List only	plications that caused	d the death I	40	4 DECAT	UR	STREET	CUMBERLA	ND MAR	YLAND	Approximete
	Physician		shock, or heart feilure. List only	one ceuse on each li	ne.	_		ay ii ig	,, 00011 00 001 0100	or respiretory en	1001,		Intervel Between Onset end Deeth
j.	/Medical		Immediate Cause (Finet		1	200	l So		/				1 come le
	Examiner		disease or condition resulting in deeth)	a	Due to (co.o.		Λ	-((ne				100-010
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	rificate be executed ng physician and es the burial-transit	Examiner	Sequentietly list conditions.	b. ————————	Due to (or es	e conseq	juenca of):						
Ó,	e exe		Sequentietly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury										
68760,	ate b hysic the b	edicai	thet initiated events resulting to deeth) Lest	C	Due to (or es	e conseq	uence of):					-	
		5		d									
Box	law requires thet the death ce les been signed by the ettendi of should be detached for use	Physician/	Pert II. Other eignificent conditions of	ontributing to death h	ut not recultin	a in the w	adorbijaa ooyoo	a aire	n in Dort I	22h Dida			o the cause of death?
P.0.	t the by the	hys	Total office of the conditions					give	mmrenti.				bably 4 Onknown
	s the	by P		(7)	porta	2100					20110	0_110	on and an analysis
Division of Vital Records,	w requires thei been signed i should be det				I .					24e. Wes e		24b. W	ere autopsy findings relieble prior to
000	aw respectively	Completed								perior	mear	CC	mpletion of cause death?
č	The lav ate hes page 2	E								1 D Y	es 20 No	1!	☐ Yes 2☐ No
ta		Bec	25. Wes case referred to medicat						26. Piece of Dear	th (Check only or	10)		
<u>5</u>	Physician: r this certific ral director,	To	examiner? 1 Yes 2 No	Hospital:	ent 2 ER	Outpetien	nt 3 DOA	Othe	r: 4 Nursing Ho	ome 5 Restd	enca 8 🗆 Ot	ther (Speci	(y)
u c	ng Ph fter thi		27. Menner of Deeth 1. Neturel 5 □ Pending	28e. Dete of tnju (Month, De	y Year) 28	b. Time of Injury	28c. ii	njury Work	et ?	28d. Describe h	ow Injury occu	irred	
Sio	Attanding r death.	cati	2 Accident Investigatio				M	1 🗆 Y	es 2□No				
\leq	or Att	Certification:	3 Suicide 6 Could not be determined		ury - At home c. (Specify)	, ferm, str	eet, factory, offi	ica		28f. Location (S City or Tow		ber or Run	el Route Number,
	pital ours e oral filled		200 Continu)								
	24 hos Fund etely	edicai	29a. Certifier (Check only one) 2 Medical Exar	ysician: To the best of niner: On the basis of end menner st	f ∉xamInetion	dge, death end/or tny	occurred et the restigetion, in m	e time	e, dete end plece, inion, death occur	end due to the c red et the time, c	euse(s) end m lete end pleca	enner es s , end due t	iteted. o the cause(s)
	To the Hospital or Attanding F within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Mec	29b. Signeture end title of certify	/ Grigineriner St	riou.		29c. Lic	ense	number	2	9d. Dete sign	ed (Month	Dey, Year)
	- S - 0		1/1/rd	1. James					6766		An. 1	30	199
	810		30. Name and address of person who	nompleted cause of d	looth (itam co	e) (Turn		26	0166		11-26		
	740							A NIT	MARYLAN	D 2150	2		
	Sta	te	31. Dete filed (Month, Day, Year)	32 Phoistr			, JIII LIKUF	TATE	, THILL DAI	D 2130			
	Registr	- 1	MAY 01 1	397 gmi	eds Signature	March	24						

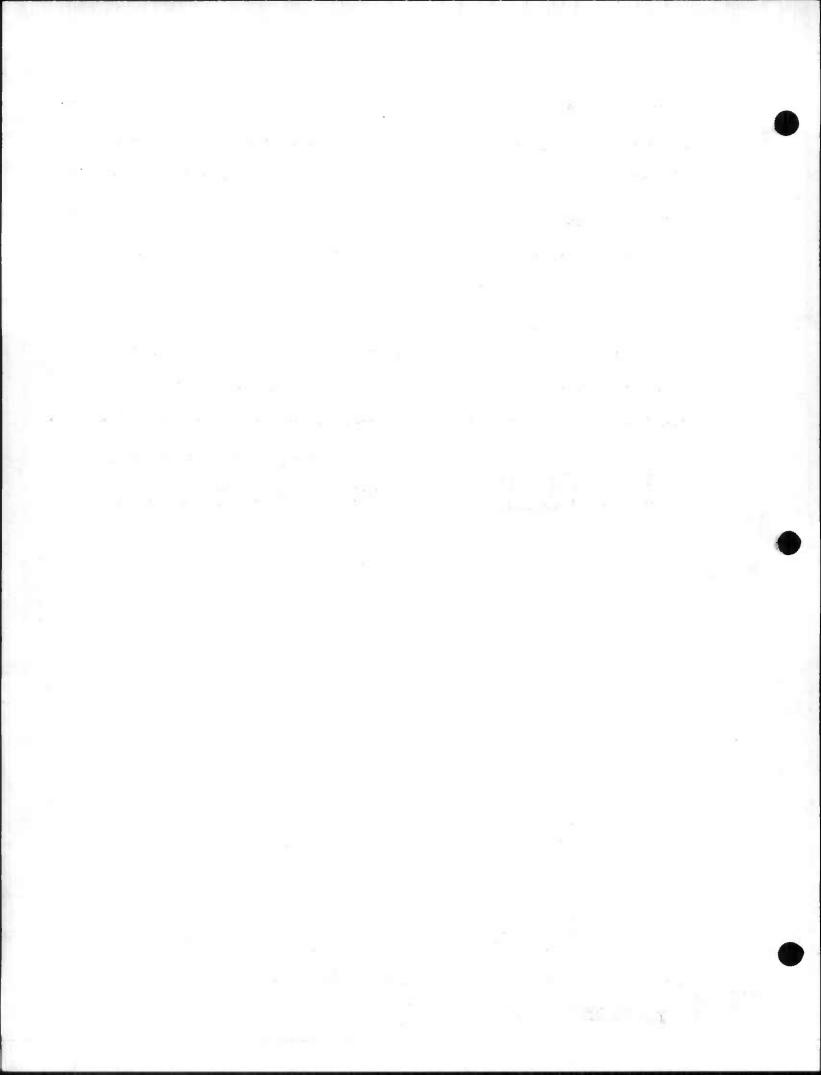


State of Maryland / Department of Health and Mental Hygiene

14614 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Yaer Garnet Ree1 1997 1:20 A.M. 2 May /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Cumberland Nursing Home Allegany Cumberland If Under 1 Yaar If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Feb 20 5. Sociel Sacurity Number 6. Sex 7. Aga (In yrs. lest birthdey) 9. Birthplece (Stete or Foreign Country) West Virginia **Funeral** Months Deys Hours 1 □ M 2 🗓 F Director 79 Yrs 234-46-7052 1918 West Usuel Residence of Decedent with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits show ns 23a or 28a-f show Director 1 X Yes 2 □ No Mineral Keyser 10e. Street end Number 10f, Zip Code 10g. Citizen of What Country? 26726 U.S.A. 1335 Cornell Street Funeral filed within 72 hours aftar daath 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, r than "natural", or iten the Medical Examiner Bleck, White, etc. 1 ☐ Never Merriad 2 N Married Baltimore, Maryland 21215-0020 b 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiana. Elementary/Secondery (0-12) College (1-4or 5+) Own Home Homemaker markad other traumatic evant, 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Surneme) Be Pagas 1 and 2 should be nant of Haalth and Mental | Smith Patti Garnet F. Queen App 19e. Informant's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Haalth a 26726 Keyser, WV Street Brenda Cannon Daughter Cornell other 1 If item or other 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 X Buriel 2 Cremetion 3 Removel from State permit. Page Department of Important: If any Injury or once. Potomac Memorial Gardens May 41 1997 Keyser, WV 26726 5 Other (Specify) of Furtheral Service biconse 22. Name end Address of Fecility Rotruck-Smith Funeral Home Keyser, 26726 85 South Main Street or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, List only one ceuse on each line. Approximete Intervet Between Onset and Daath **Physician** /Medical Immediete Ceuse (Ftnat 3 days neumonea diseesa or condition rasulting in deeth) Examiner Due to (or es e consequenca of) Physician/Medical Examiner The law requires that the death cartificate be axecuted the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceusa (Disaasa or Injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, physician Dua to (or es e consaguance of) Part II. Other significent conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Division of Vital Records, Completed by 8 24b. Were eutopsy findings evalleble prior to completion of cause of deeth? 24e. Was en eutopsy parformed? certificata has 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director, I Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, straet, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es steted.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Data signed (Month, Dey, Year) and 133280 0 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) MILS 21502 625 Kent Avenue Cumberland, MD Sunil K. Gupta, M.D. 31. Date filed (Month, Day, Yeer) 32. Registrer's Signeture State Registrar



State of Maryland / Department of Health and Mental Hygiene

Physical Medic	icai iner	4e. Feclity Neme (If not institution, give	ULA LA						2. Dete of Dee	ath		
Exami Funera Director	iner					ROBO	SSON		Month May 2,	Dey	Year	3. Time of Deeth 7:48 pm
Director		Memorial Hospital	streat end number)		-			4b. City, Town, or	Location of Deeth	4c. County		, , , , , , , , , , , , , , , , , , ,
Marylend f show	_	5. Social Security Number 6. Se	ex 7. Ag □ M 2□XF	ge (In yrs. I	last birthday) Yrs.	If Und Month	er 1 Year s Deys	Cumber1 If Under 24 Hrs Hours Min.	8. Date of Birt	Alle (, Year) 0 1911		ice (Stete or Foreig Y) LAND
	ō	10e. Stete 10b. County		,	, Town or Lo						10	d. Inside City Limits
h the l	Director	MARYLAND ALLEGAN 10e. Street end Number	Y	CUM	(BERLA)		ip Coda			10g. Citizen of	Whet Countr	
23a c			DDITION				2150	2		U.S.A	١.	
15-UUZU 72 hours effer death with the Marylend *natural; or items 23s or 28s-f show soles Exeminer must be notified at	by Funeral	3 X Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒ I If Yes, Giva Yeer or Dates:					dispenic Orlgin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Red Ble Specif	ce - America ck, White, e	tc.
within ane.	Completed	15. Dacadent's Edi (Specify only highest gred Elamentary/Secondary (0-12)	ucation de completed) College (1-4or 5	5+)	16e. Deced (Giva life. L	kind of v DO NOT	vork done use retire	during most of wo	rking	16b. Kind of B		
e filed other vent,	Be Co				поозе	KEI	LPEK	18. Mother's Na	me (First, Middle,		KEEP	ER
Maryiand d 2 should be file th end Mentel Hy 7 is marked othe traumatic event	ToB	FRANK TYSON						HULDA	HARTSOCK			
Mar 12 sh h end 7 is m traum		19e. Informent's Name/Reletionship (T)	ype, Print)		19b. Meilin	g Addra	ss (Street	end Number or Ri	urel Route Numbe	r, City or Town	Stete, Zip (Coda)
nore, nore Heal if item 2 or other		NORMA MANGES 20a. Method of Disposition VQXBuriel 2 □ Cremation 3 □ 6 4 □ Donetion 5 □ Other (Specify)		20b. Pl	em <i>etery</i> , cren	netory o	other ple	NUE CUMB ⇔) AY 6, 19	Dete	MARYLAN 20c. Location	City or Tow	n, Stete
Dalting permit. Per Department Important any injury		21. Signeture of Funeral Service Licens		,	ME	Name	end Addre	ss of Fecility AMS FUNE	RAL HOME			KILAND
Physician /Medical Examiner		23e. Pert1. Enter the disease, or comp shock, or heert failura. List only of Immadiate Ceuse (Final disease or condition resulting in daath)	licetions thet caused ne causa on each line. Probab1	e Ca	. Do not ente	Arr	hythn		c or respiretory en	rest,	1 1	Approximete ntarval Between Onsat and Deeth
auth certificate be executed ettending physician end for use as the buriel-transit	in/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Undartying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest	c	Due to (or	es e conseques es e conseques	uance of):	-				
death he etter	Physician/N	Pert II. Other significent conditions con	ntributing to deeth b	ut not resu	Iting in the ur	nderlylng	cause giv	ren In Pert I.	23b. Did t	obacco uee co	ntribute to 1	the causa of death
requires that the death cert een signed by the ettendin hould be deteched for use	by Phy	Pneumonia							1 🗆 1	os 2 No	3 Probe	ably 4 Unknow
2 s b	Completed								24a. Was a perfor	med?	avei	e eutopsy findings leble prior to pletion of cause eeth?
= F # G		25. Wes casa rafarred to medical						OS Plane of De	1 U Y		10	Yes 2□ No
Phys ral di	ition: To Be	avaminer?	1 A Inpatia 28a. Data of Inju (Month, De	ry	ER/Outpetien 28b. Time of Injury	t 3□ 0	28c. Injur Wor	ier: 4 Nursing H	ath (Check only of flome 5 Resid	enca 6 □Oth		
bal or Attending rs efter death. in Director: After ed in by the fune	Certification:	3 Sulcide 6 Could not be determined	28e. Pleca of Injubuilding, etc.	ury - At hor c. (Specify	me, farm, stre	eet, facto	ory, office		28f. Location (S City or Tow		per or Rural	Floute Number,
To the Hospital or A within 24 hours effer To the Funeral Dire completely filled in b	edicai	29a. Certifiar (Check only one) 1 € CertifyIng Phy 2 Medicat Exami	elclen: To the best of ner: On the basis of end menner ste	examinet	vledga, deeth lon end/or inv	occurre	d et the tir on, In my o	ne, dete end pleca pinion, death occu	a, end due to the durred et the time, o	euse(s) end melete end plece,	enner es ste end due to t	ted. the ceuse(s)
To the within the total	Σ	29b. Signeture end title of certifier	1 4	/		2	9c. Licens		-	29d. Date signe		
3		30. Nama and addrass of person who co	ompleted ceusa of d	aath (Itam	23a) (Typa, I	Print)	D	33280		May S	, 19	997
	ate	Dr. S. Gupta, John 31. Date filed (Month, Day, Year) WAY 05 189	3d Banistra				lg.,	Cumberla	nd, MD	21502		

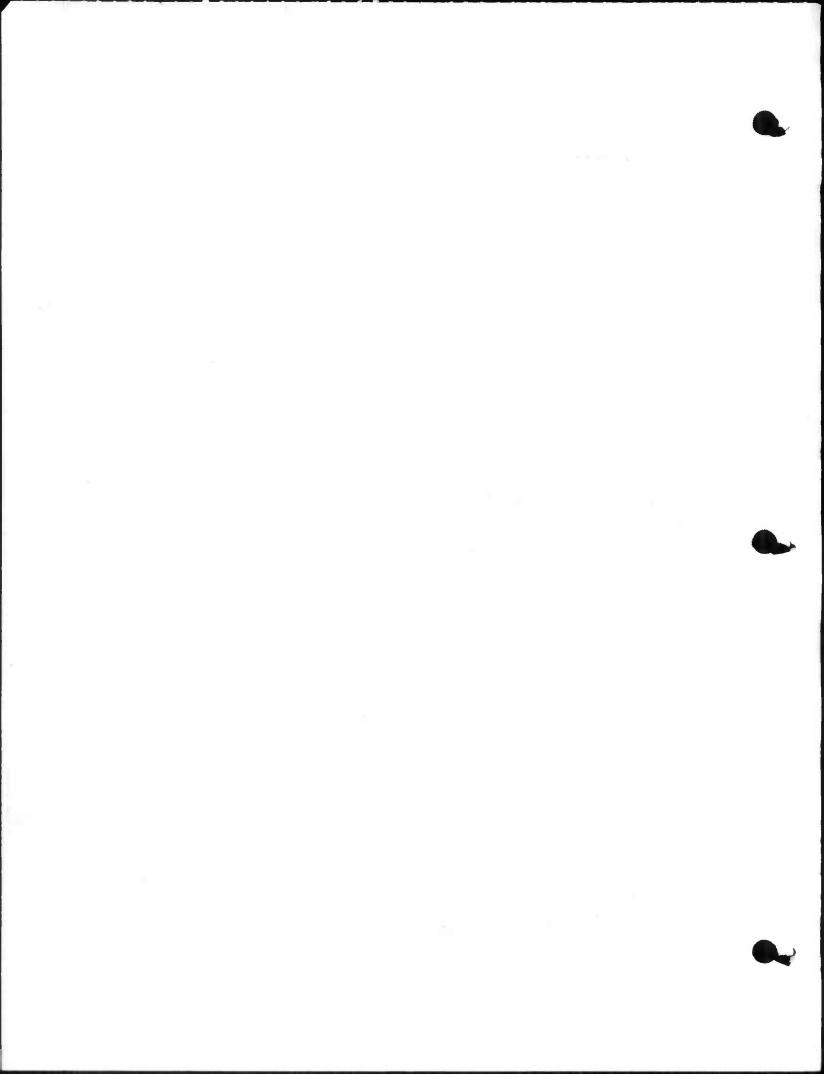
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within nours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burda-transit nermit. Pages 1 2 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF			HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	F DEATH		3.	TIME OF DEATH
	ROSA LYNETTE			RIGGIN		МАҮ	2 ~	1997°	EAR	1:00 AM M
	4. SOCIAL SECURITY NUMBER 5	8. AGE (n yrs. last birthday)		IF UNDER 24 HRS.	7. DATE OF	BIRTH Day, Year)	8.	BIRTHPL/ Country)	ACE (State or Foreign
	213-20-2332	□ M 2 X) F 65	YRS.	MONTHS DAYS	HOURE MIN.			931		SINIA
_	9e. FACILITY NAME (If not institution, give street	·			OR LOCATION OF D			9c. COUNTY	OF DEAT	Н
DIRECTOR	1210 MARKET ST.	, NEWTOWN APT	S. D8	POCOMOR	CE CITY			WORC	ESTE	R
딥	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c, CIT	Y. TOWN OR LOCA	TION				T 10	d. INSIDE CITY
H H	MARYLAND WORCES	TFR		COMOKE						LIMITS?
	10e. STREET AND NUMBER	1211			f. ZIP CODE			10a CITIZEN		T COUNTRY?
FUNERAL	1210 MARKET STREET				21851				S.	
5		2. WAS DECEDENT EVER IN		13. WAS DE	CENDENT OF HISPA	NIC ORIGIN?	(Specify Yes		RACE -	American Indien,
	1 Never Married 2 Merried	FORCES? 1 YES			secify Cuben, Mexico S 2 X NO Speci		en, etc.)		Black, W Specify:	hite, etc.
ВУ	3 Nidowed 4 Divorced				Α/				ap conj.	WHITE
ETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	'ION mpleted)	(Give kind of	Work done during m	ON ost of working	16b. K	IND OF BUS	INESS/INDUS	TRY	
빌		College (1-4 or 5 +)	life. Do NOT u							
COMPL	1.7. FATHER'S NAME (First, Middle, Last)		HOUSEW	TFE)WN H			
-	NEILIE KELLEY				18. MOTHER'S NA			Surname)		1
BE	19e. INFORMANT'S NAME (Type/Print)		19h MAILING	ADDRESS /Street	ETHEL and Number or Rural			Sum The Co	eda l	
2	ORVILLE J. RIGG	TN .IR			SBURG R					21062
	20e. METHOD OF DISPOSITION	20h		OF DISPOSITION (N		OAD,		CATION — City		
	1 K Burlel 2 Cremetion 3 Remova 4 Donation 5 Other (Specify)	I from State Ceme	IVET CEN	(ther place)		5/5/9		CTESBURG		
	21. INGNATURE OF MUNERAL SERVICE LICEN	SEE		22. NAME A	ND ADORESS OF FA	ACILITY		LILOZOIK	J, 11D.	
	Homework	Nonn	NAME OF		V FUNERAL			NOTCO	ABIAIT	21853
7	23. FART I. Enter the diseases, or com	nplicatione that caused	MOO295	not enter the me	SOMERSET	AVE.	, PRI	NUESS	ANNE	Approximate
1	snock, or nesrt fellure. Lis	t only one ceuse on ee	ch line.		or aj ing, sac	00 001010	o or respir	utory arrest	• •	Intervel Between
Ч	IMMEDIATE CAUSE (Finel disease or condition	COPALL	174	680						Onset and Death
	resulting in deeth) e	CO PO NO DUE TO (OR AS A	CONSEQUENCE O	F):	25101	7				
z		ASCUD								
음	Sequentially liet conditions, if sny, lesding to immediate	OUE TO (OR AS A	CONSEQUENCE O	F):						
<u>5</u>	CAUSE (Disesse or injury									
ᄩ	thet initieted events resulting in deeth) LAST	OUE TO (OR AS A	CONSEQUENCE O	F):						
CERTIFICATION	d									
AL (PART II. Other significent conditions of	ontributing to deeth bu	it not reculting	in the underlyin	g ceuse given in	Part I. 2	4a. WAS AN			RE AUTOPSY FINDINGS
						1	PERFOR		CO	MILABLE PRIOR TO MPLETION OF CAUSE DEATH?
MEDIC										YES 2 NO
ä	DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF	F DEATH YE	S X NO [UNCERTAI	N□				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	6. PLACE OF DEA	TH (Check only one) OTHER:						
YSI	1 YES 2 NO 1	☐ Inpatient 2 ☐ ER/Outpe	itlent 3 DOA	4 Nursing Hon	ne 5 Residence	6 🗆 Other (S	Specify)			
H	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	28b. TIM	JURY WO	PRK?	28d. DESCF	NIBE HOW IN	JURY OCCUR	ED	
BY	2 Accident Investigation	20 71 407 07 11 11 11			YES 2 NO					
8	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Special	— At home, ferm, : fy)	street, fectory, offic	•		ION (Street e. Town, State)	nd Number or I	Rural Route	Number,
COMPLETED	29e, CERTIFIER									
MP	(Check only 1 12) CERTIFYING PHYSICIAL	N: To the best of my knowle								
8	one) 2 MEDICAL EXAMINER: C	on the beele or exemination	end/or investigation	on, in my opinion, o	leath occured at the	time, date en	id plece, end	due to the co	ruse(s) en	d menner ee stated,
BE	296. SIGNATURE AND TITLE OF CERTIFIED	at w	6		DO2			29d. DATE SI	GNED (Mg	inth, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CALLES OF DEA	TH /ITEM AT /	Orient	101	1 -1 -0		- 3/	4	()
1	1 J. G. Sant				reet, P	OCOm(oke.	Md.	218	351
	31. DATE FILED (Month Des -per)	S. RESIDENTIA AND	URE	3011 00		JUDIN	120/			
	MAY 0 2 1991 June		-							





97-2577-015 wlc CL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

0	may	

		R. Item 23,27 Per 1. Decedent's Name (First, Midd		J. 17 0 41	J. 1Ja			Death	2. Date				. Time of Death
Physici		Clark Harvey	Richard	son. Jr.					Month			Year	0616-
/Medic		4e. Fecility Name (If not institution						4b. City. Tow	n, or Location of		199 c. County		0646a
Examin	ler	5 NORTH VIEW											
Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Unde	er 1 Yeer	CONOW If Under 2			CEC		State or Foreign
Funeral Director		None	1⊠ M 2□		Yrs.	Months	Days 4	Hours	Min. (Mont	of Birth h, Dey, Year	7 7		e (Stete or Foreign
		Usual Residence of Decedent				<u> </u>	+		may (5, 199	/ 1	Maryla	na
ural', or Items 23a or 28a-f ahow al Examiner must be notified at		10a. State 10b. Count	у	10c. C	ity, Town or Lo	ocation						10d.	Inside City Limits
item 27 is marked other than "netural", or items 23a or 28a-f show other traumstic avent, the Medical Examiner must be notified at	jo	MD Cec	i1	Co	nowing	Э							1 ☐ Yes 2 ☑ No
28a	Director	10e, Street end Number				10f Z	ip Code			10g G	tizen of W	What Country's)
20 00	ā		D									viiat Godintiy	
n 23	Funeral	5 North View		Decedent Ever In	118 12		1918		of (Consider Van		SA 14 Page	e - American	Indian
ğ.	'n		Armed	Forces?	0,5. 13.	If Yes, sp	ecify Cub	an, Mexican,	n? (Specify Yes of Puerto Rican, etc.	b.)		k, White, etc.	
mg.	by F	1 ☑ Never Married 2 ☐ Ma 3 ☐ Widowed 4 ☐ Divorce	. If Yes,	es 2 🛭 No Give		1 🗆 Yes	2 🖾 No	Specify:			Specify:	Whit	e
ale.	B			or Detes:	100 D	alamata (Ila				101-1	Cadal D		
og o	Completed	(Specify only high	nt's Education est grede complet	9d)	16a. Dece (Give	kind of w	ork done	during most of	of working	100. F	(Ind of Bu	siness/Indust	ry
than Da.M	m	Elementary/Secondary (0-12)	Colleg	e (1-4or 5+)							Marrar	e rrowle	o d
umetic event, th		() 17. Father's Neme (First, Middle	(act)		Neve	er Wo	rked		s Neme (First, M			r work	eu
A	Be	Clark Harvey		On					Morriso		II Sumam	9)	
metic	10			011									
raur		19e. informant'a Name/Relation Clark Harvey	ship <i>(Type, Print)</i> Richards:	on. Eath	19b. Maili	ng Addre	SS (Street	end Number	Conowins	umber, City	or Town,	Stete, Zip Co R	de)
ž.		SALE MILES SERVICE AND RESIDENCE AND RESIDENCE						W DI.					
or other traume		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 □Removal fr		Place of Dispo cemetery, cre	metory or	other ple	ce)	Date	20c. L	ocation -	City or Town,	Stete
y injury or		4 ☐ Donation 5 ☐ Other (The second second	st Noti	tingh	am C	emeter	y May 14	1997	Col	lora M	D
mportant any injury anse.		21. Signature of Funeral Service	Licensee					ss of Facility					
any sus		1	42	1	R	Т.	Foar	d Fune	ral Home	P.A	•		
		23a. Part1. Enter the disease, o	complications th	et caused the dea	ath. Do not en	ter the mo	Quee de of dylr	n St. ng, such as c	Rising S erdiac or respirate	ory arrest,	219	I I	proximate
sician		shock, or heart fallure. Lis	t ooly one cause o	in each line.								Int	erval Between iset and Death
edical		immediate Suse (Final disease or andition	543										
niner		disease or andition resulting in deeth)	a. C0	NGENITAL H	EART DIS	EASE							
	ē			Due to	(or es e conse	quence of):						
nsit	Examiner		b									1	
al-tra	Xai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to	(or as a conse	quence of):						
physician and s the burial-transit	al E	cause. Enter Underlying Cause (Disease or Injury	C									į	
the	edical	thet initiated events resulting in death) Last		Due to (or es e consec	quence of)	:						
d for use es t			d									į	
or us	Physician/M		<u> </u>										
the a	/sic	Part II. Other algnificant conditi	ona contributing t	deeth but not re	sulting In the u	inderlying	cause giv	ven in Pert i.	23b.	Did tobacce	o use con	tribute to the	cause of death
2 8										1 Yes	2□ No	3 Probab	ly 4 Unknow
50	ρ						-						
07 TO	장								24a.	Wes en auto performed?	opsy	availal	autopsy tindings ble prior to
noon	-								<u>.</u>	•		compi of dea	etion of cause th?
s been s 2 should	piet									1□ Yes 2	2 □ No	1 🗆 Y	es 2 No
S CA	ompiet							26 Place	of Death (Check of				
8 CA	e Completed	25. Was case referred to medical	ai l						JI DOULL LOWOUN C	only only			
80 CA	o Be	examiner?	Hospital:	□ Inpatient 2	TER/Outpation	at 2 🗆 🗅	Oth		ing Home EFT	Decidence	D □Oth	ar (Canadha)	
his certificate hes al director, page 2	To Be		Hospital: 1	☐ Inpatient 2[_		OA	ner: 4□ Nurs	sing Home 5				
his certificate hes al director, page 2	To Be	examiner? XXYes 2 No 27. Manner of Death 1 XXNaturai 5 Pendi	Hospital: 1 28a. Da	☐ Inpatient 2 [ate of injury fonth, Dey Year)	ER/Outpetier 28b. Time o Injury	f	28c. Injur Wor	ner: 4□ Nurs ry et rk?	28d. Desc	Residence ribe how Inju			
his certificate hes al director, page 2	To Be	examiner? XCXYes 2 No 27. Manner of Death 1 Matural 5 Pendi 2 Accident Invest 3 Suicide 6 Could	Hospital: 1 28a. De (A) igation not be	ate of injury fonth, Dey Year)	28b. Time o injury	f M	28c. Injur Wor	ner: 4□ Nurs	28d. Desc	ribe how Inju	ary occurr	ed	nuda Musebas
ector: Atter this certificate hes by the funeral director, page 2	To Be	examiner? XCXYes 2 No 27. Manner of Death 1 Matural 5 Pendi 2 Accident Invest 3 Suicide 6 Could	Hospital: 1 ng 28a. De (N) igation not be noted 28e. Pl		28b. Time o injury	f M	28c. Injur Wor	ner: 4□ Nurs ry et rk?	28d. Desc	ribe how Inju	nd Number		oute Number,
by the funeral director, page 2	Certification: To Be	examiner? XTXYes 2 No 27. Manner of Death 1 XTNaturai 5 Pendi 2 Accident Invest 3 Suicide 6 Could 4 Homloide detern	Hospital: 1 28a. De (N igation not be nined 28e. Pl bu	ate of injury fonth, Day Year) ace of injury - At l ilding, etc. (Spec	28b. Time o injury home, farm, str	M reet, facto	28c. Injur Wor 1 -	ner: 4 Nurs ry et rk? Yes 2 N	28d. Desco	ribe how Inju ion (Street e or Town, Stet	nd Number	ed er or Rural Ro	
ector: After this certificate hes by the funeral director, page 2	Certification: To Be	examiner? NAMENER OF DEATH 1 PANETURA 2 Accident 3 Suicide 4 Homloide 29a. Certifier (Check only) 1 VYes 2 No 5 Pendi Invest 6 Could detern	Hospital: 1 28a. Di (N igation not be nined 28e. Pl bu ng Physician: To Examiner: On th	ate of injury fonth, Dey Year) ace of injury - At I ailding, etc. (Spec the best of my kn e basis of examin	28b. Time o Injury	M M reet, facto	28c. Injur Wor 1 -	ner: 4 Nurs ry et rk? Yes 2 Ne	28d. Desco	ion (Street e or Town, Stet	ond Number	er or Rural Ro	d.
Funeral Director: After this certificate hes stell filled in by the funeral director, page 2	edicai Certification: To Be	examiner? XCYes 2 No 27. Manner of Death 1 Maturai 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homloide 29a. Certifier (Check only one)	Hospital: 1 ng igation not be nined 28e. Pl but not be nined 28e. Pl but not be not b	ate of injury fonth, Dey Year) ace of injury - At lidding, etc. (Spec the best of my kn	28b. Time o Injury	M reet, facto h occurred vestigetio	28c. Injur Wor 1 - ry, office	her: 4 Nurs ry et rk? I Yes 2 No	28d. Desco	ion (Street e or Town, Ster to the cause(sime, dete en	nd Number (e)	er or Rural Ro	d. e ceuse(s)
Funeral Director: After this certificate hes stell filled in by the funeral director, page 2	Certification: To Be	examiner? NAMENER OF DEATH 1 PANETURA 2 Accident 3 Suicide 4 Homloide 29a. Certifier (Check only) 1 VYes 2 No 5 Pendi Invest 6 Could detern	Hospital: 1 ng igation not be nined 28e. Pl but not be nined 28e. Pl but not be not b	ate of injury fonth, Dey Year) ace of injury - At I ailding, etc. (Spec the best of my kn e basis of examin	28b. Time o Injury	M M reet, facto	28c. Injur Wor 1 pry, office	A Nurs Nurs	28d. Desco	ion (Street e r Town, Stef o the cause(sime, dete en	nd Numberel	er or Rural Re nner as stete and due to the	d. e ceuse(s)
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State Registrar

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month MARY 10:304M T. SMITH 97 -21-/Medical 4e. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOBPITAL BERLIN WORCESTER 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** 10 M 20 F Deys 164-03-3036 Yrs. Director NOV. 28, 1912 MANAYUNK, PA. Usual Residence of Decedent 10a Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "netural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐XNo WORCESTER W. OCEAN CITY 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9918 ELM STREET 21842 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Yeer or Dates: 11. Merital Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainess/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NONE HOUSEWIFE other t 8th permit. Peges 1 and 2 should be file.
Department of Health and Mentai Hy, important: if Nem Z7 is merked othe any injury or other transmit 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be SOPHIA BARLIK FRANK SIERANT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) BARBARA BANKS, DAUGHTER P.O. BOX 2, FRANKFORD, DELAWARE 19945 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Toremation 3 Removal from State 4 Donation 5 A Other (Specify) SUNSET MEMORIAL PARK 4/26/97 BERLIN, MARYLAND neral Service Vice 21. Signeture of Pur 22. Name end Address of Facility MELSON FUNERAL SERVICES, LTD. FRANKFORD, DELAWARE 19945 23a. Pert1. Ento the diseas or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel 3-4 WKS a RESPIRATORY FAILURE OUE TO CHE PNEUMONIA disease or condition resulting in death) Examiner Examiner LG MON. ATRIAL FIBRILLATION physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) VANCO-RESISTANT ENTEROCOCCUS, MALNUTRITION, AMEMIA ¿ G MON Physician/Medical Due to (or as e consequence of): LG MON. S/P YULVECTOMY FOR VULVAR CA, RECURRENT Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown RENAL INSUFFICIENCY , PROTEINURIA , ELECTROLYTE AKNORMALITIES d be dete ģ Be Completed 24a. Wes an eutopsy performed? 24b. Were autopsy findings evallable prior to completion of cause of death? PERIPHERAL EDEMA 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No RIGHT DEEP VENOUS THROMEOUS 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Menger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Box 68760. P.O. Records, of Vital or Attending Physicien: To the Hospital or Attending Prays:
Within 24 hours after death.
To the Funeral Director: After this c
completely filled in by the funeral dir Division

altimore, Maryland 21215-0020

State Registrar

edical

29a. Certifier

29b. Signeture and title of cartifier

#18 MASON-DIXON SHOPPING CENTER SELBYVILLE DE. JOY MADARANG-LEWIS 31. Date filed (Month, Day, Year) APR 23 1997 32. Registrar's Signature

/M.O.

INTERNIST 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) and manner stated.

29c. License number

D0050929

29d. Date signed (Month, Day, Year)

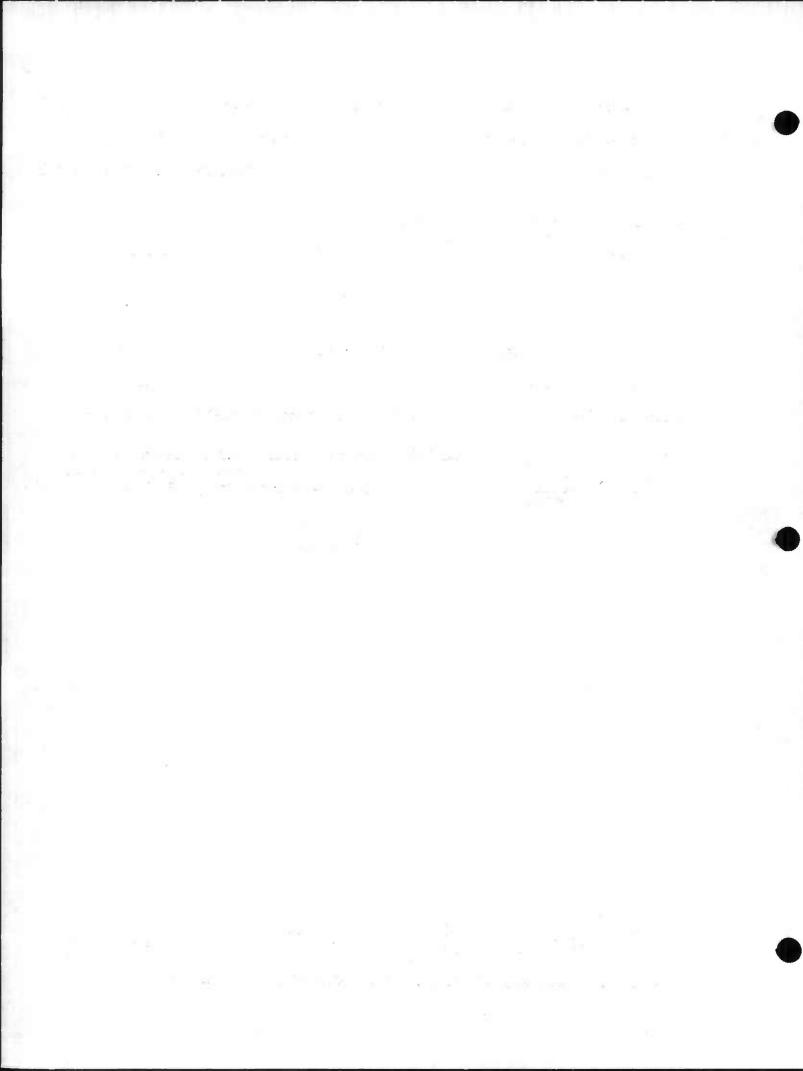
-211 -- 12/ a transfer four argents through the

State of Maryland / Department of Health and Mental Hygiene

14619 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth April April **Physician** 13, 1997 Smith 10:45AM Julia Ann /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton Hours Min. 8. Dete of Birth (Month, Day, Year) NOV 21, 1901 5. Social Security Number If Under 1 Year 6. Sax 7. Age (In yrs. lest birthday) **Funeral** 9. Birthplace (State or Foreign 10 M XXF Months Deys Yrs. South Carolina 177-26-1194 95 Director Usuel Residence of Decedent with the Marylend 10e. State 10b. County 10c. City, Town or Location r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Clinton Maryland Prince George's Pine View Manor Nursing 10g. Citizen of Whet Country? 10f. Zip Code 20735 U.S.A. 9106 Pineview Lane Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Black 1 Yes 2 No Specify: þ 3 DWidowed 4 Divorced Be Completed 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 8th N/A Homemaker Home permit. Pages 1 and 2 should be filed Department of Heelth and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Carrie Jacobs James Henry 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code) 11216 Green Dragon Court Columbia, MD 21044 James A. Smith 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Cremetion 3 Removal from Stete 4 Donetion 5 Other (Specify) Oakland Cemetery April 18,1997 Hanover TWP, PA 21. Signeture of Funaral Service Licenses Lee Funeral Home, Inc. 22. Name and Address of Facility 6633 Old Alexandria Ferry Rd Clinton, MD 20735 23e. Part1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician Immedieta Cause (Finel diseese or condition resulting in deeth) /Medical 1 Wk Bilateral Pneumonia Examiner Due to (or es e consequence of) Examiner The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in daath) Last and the burial-tran Due to (or es a consequence of): P.O. Box 68760. ettending physician for use as the burie Physician/Medical Dua to (or as e consequence of) igned by the el Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contributs to the cause of death? signed by 1 Yes 2 No 3 □ Probably 4 ☑ Unknown Hypoxemia Division of Vital Records, þ 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? been s certificate hes 1 Yes 2 No 1 ☐ Yes 2 ZNo or Attending Physician: efter death.

Director: After this certifications Be 25. Wes case referred to medical 26. Plece of Death (Check only one) 2 1 Yes 2 No 1 Xinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA filled in by the funeral Certification: 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral Di complataly filled is Certifying Physician: To tha best of my knowledga, daeth occurred at the time, data and plece, and dua to tha cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and plece, and due to the cause(s) and magner stated. edicai 29a, Cartifier (Check only one) 29b. Signeture end tiple of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D15513 30. Neme and eddress of person who complated ceuse of daeth (Itam 23e) (Type, Print) #2 St. Patrick Drive Waldorf, Maryland 20603 Lucio S. Villa-Real, MD 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State APR 3 0 1997 Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** Day Smitz dv. April 36, 1997 4b. City, Town, or Location of Death 4c. County of De AMES + OREMAN 1280 /Medical 4e. Facility Nema (if not Institution, giva straat and numbar) 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO | If Undar 1 Year | If Undar 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 1 - 28 - 1931 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Birthplaca (Stata or Foreign Country) Months 65 Yrs. 214-28-3326 12 M 2□ F Director Usual Rasidance of Dacedant the Maryland 10a. Stata 10b County 10c City Town or Location 10d. Insida City Limits MD ns 23a or 28a-f st Funeral Director Omerset rincess 1 Yas 2 No 10e. Street end Numbai 10f. Zip Coda 10g. Citizen of What Country? 29615 4853 Sand death Items 2 12. Was Decedent Ever in U.S. Armed Forcas? 13. Wes Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. the Medical Examiner Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after 1 Navar Marriad 2 Married 1 X Yas 2 ☐ No If Yas, Giva Yaar or Datas: 21215-0020 ò 1 ☐ Yas 2 XNo Specify: by Black 3 ☐ Widowad 4 ☐ Divorced Specify: "natural", Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lift DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is merked other than any Injury or other traumatic event, the Meganga. Elamantary/Secondary (0-12) Collaga (1-4or 5+) 124 Baltimore, Maryland 17. Fathar's Nama (First, Middla, Lapt) 18. Mothar's Nema (First, Middla, Maldan Surnama) Be silbert a 000 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 29415 Deals Fsland Lovan Princess Ro MD 21853 20b. Place of Disposition (Nama of camatary, crematory or other place) 20a. Mathod of Disposition 20c. Locetion - City or Town, Steta Data John Wesley Cemetery

22. Name and Addrass of Facility

Anthony E. Ward Funeral

Anthony E. Ward Funeral

Anthony E. Princes:

22. Name and Addrass of Facility

Anthony E. Ward Funeral

Anthony E. Princes:

23. Anthony E. Princes: 1 Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signetura of Funaral Sarvice Licensee 23a. Part 1. Enter the disaasa, of complications that caused the dear Do not antar tha mode of dying, such as cerdiac or raspiratory arrast, shock, or haart failure. List only one cause on each line. Ave. Princess. 21853 Physician GI bleed /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner Sequantially list conditions, if any, laading to Immadiata ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting In daath) Last Division of Vital Records, P.O. Box 68760, attending physician for use es the buria or Attending Physician: The law requires that the death certificate be Physician/Medical Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the undarlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings aveilable prior to completion of cause of death? peen certificate 1 Yas 20 No 1 ☐ Yas 2 ☐ No Be 25. Was cesa rafarrad to medicel axaminar? 26. Placa of Daath (Check only ona) 1□ Yas 20 No 2 Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28c. Injury at Work? 27. Mannar of Death 28d. Dascribe how injury occurred Certification: 28b. Tima of 1X Natural 5 Panding Invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, fectory, offica building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, due to the cause(s) and manner stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signatura and titla of certifier 29d. Date signed (Month, Day, Year) 29c. License number 100 30. Nama and address of parson who complated ceusa of daath (Itam 23a) (Type, Print) Dr. Charles Stegman 30434 Mt. Vermon Rd. Princen Anne, Ad 32. Ragistrar's Signatura 31. Data filed (Month, Day, Year)

Registrar

APR3 0 1997

AND THE PROPERTY OF THE PARTY O And areas of the second 14 Principle of Spilotone and the rough Edward Standard Editing gar and a manufactured to their manufactured 1955 — André Andrews Prince Princ

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Emma Jane Smith Apri 1997 10:16 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death 7529 Cedartown Road Snow Hill Worcester If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) if Under 1 Year Birthplece (State or Foreign Country) Deys 1 M 20 F Months August 11,1896 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2KNo Snow Hill Worcester 10f. Zip Code 10g. Citizen of What Country? 7529 Cedartown Road Snow Hill USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced African American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) James Richardson Nora Holloway 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Wilson Smith/son 7536 Cedartown Road - Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Wesley Church Ceme. 04/12/97 Snow Hill, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature of Funeral Service Licansed Jolley Memorial Chapel Flatt 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. ASCUD 24-HOURS Due to (or es a consequence of) Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4R Unknown

Physician /Medical **Examiner**

Physician

/Medical

Director

Funeral

þ

Completed

5. Social Security Number

214-36-6062

10a. State

Maryland

11. Maritel Stetus

10e. Street and Number

7th grade

20a. Method of Disposition

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mehal Hyghen.

Important: If item 27 is marked other than "natural", or hems 23s any Injury or other transfer avains.

Baltimore, Maryland 21215-0020

the Maryland

Examine Physician/Medical þ Completed Be Certification: To

27.

To the Hospital or Attending Physician: The law requires that the death certificate be associated within 64 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completally filled in by the funeral director, page 2 should be deteched for use as the burlansit

Division of Vital Records, P.O. Box 68760,

Immediate Cause (Finel disease or condition resulting In death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 25.

29b. Signeture and title of certifier

						24a. Wes en eutopsy performed?	24b. Were autopay findings eveilable prior to completion of cause of death?
						1 ☐ Yes 2人 No	1 ☐ Yes 2 ☐ No
25. Was case referre	ed to medical				28. Place of De	eeth (Check only one)	
examiner?	lo	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA	Other: 4 Nursing	Home 5 PResidence 6 □Oth	ner (Specify)
27. Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending Investigation		28b. Time of Injury	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	rred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, streety)	ot, factory, of	ffice	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,
29a. Certifier (Check only one)	Certifying Phy Medical Exam	veiclan: To the best of my knot liner: On the basis of examina and manner stated.	owledge, death o ation and/or inve	occurred at t stigation, in	he time, date and place my opinion, death occ	ce, end due to the cause(s) and me curred at the time, date and place,	anner es steted. and due to the cause(s)

29c. License number

06241

29d. Date signed (Month, Day, Year)

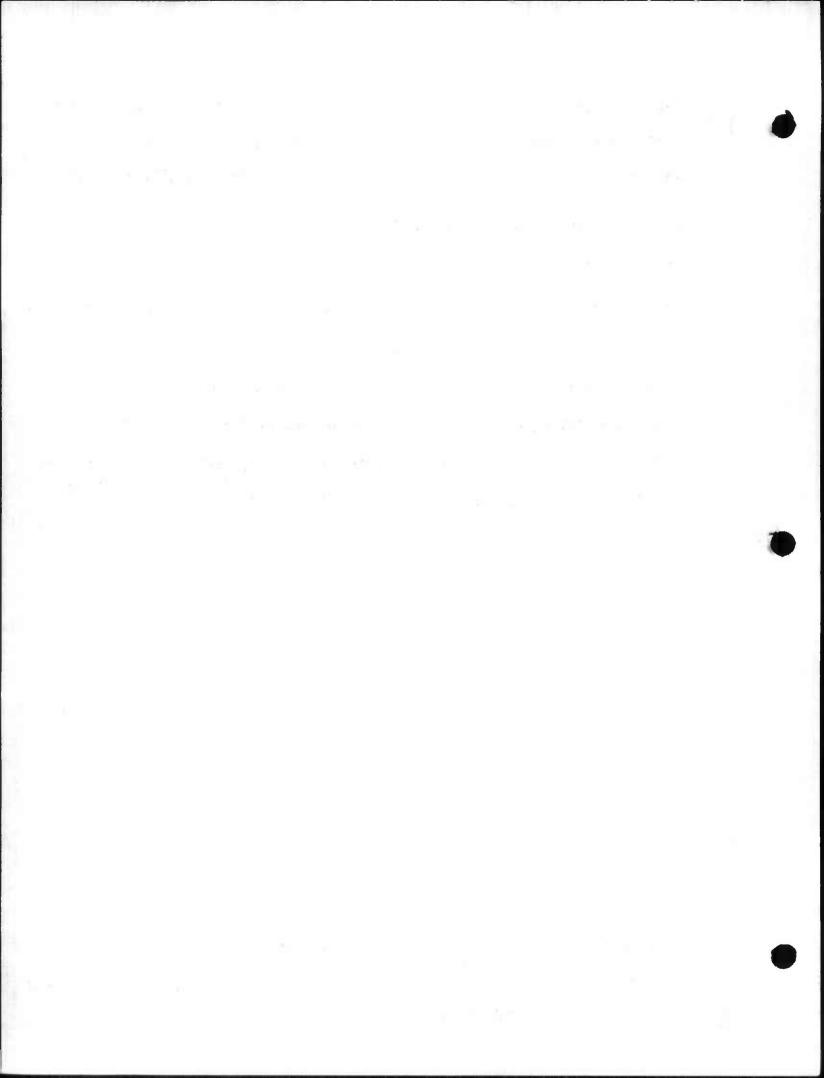
203 SNOW ST. SWOUHILL MD. 21863

State Registrar

Medical

32 Registrar's Signature

of person who completed cause of death (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene 0.7

97 1462

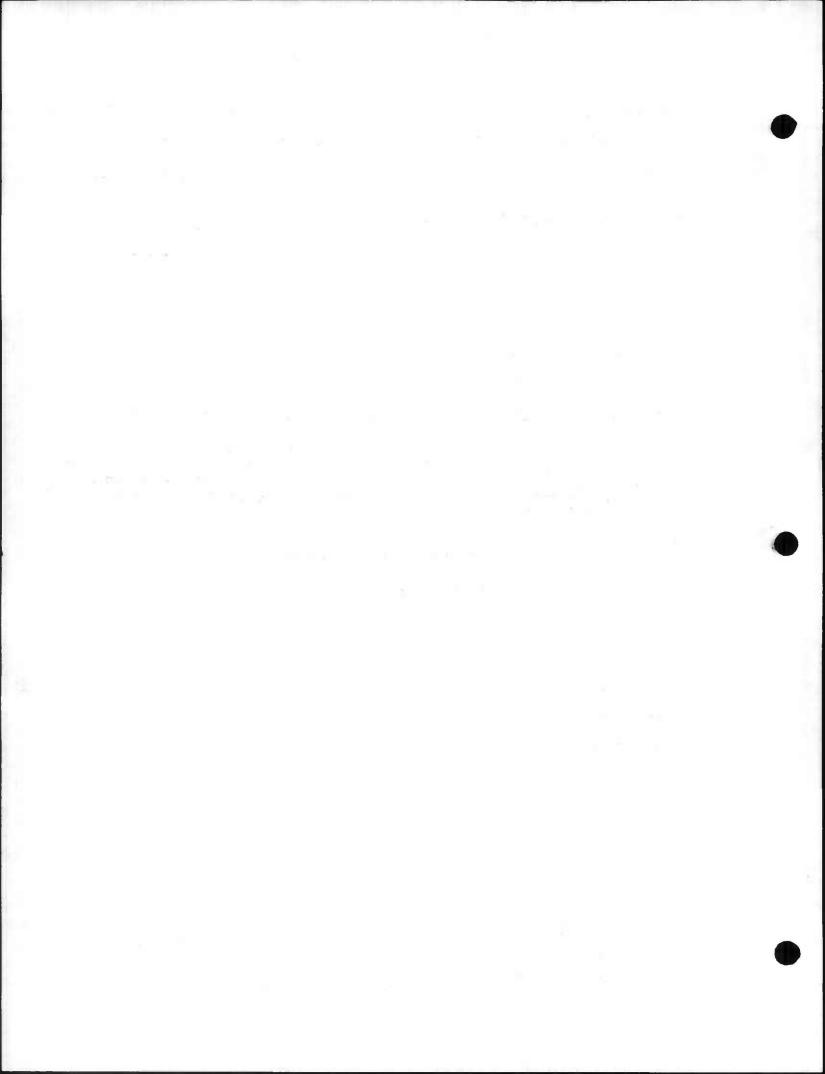
_						Cer	tificate c	of Death	R	eg. No.) /	14022
П	Physic	ian	Decedent's Name (First, Middle, Last,						2. Date of Dear Month	th Day	Year	3. Time of Death
	/Medi		MARY LELAH SMITH						MAY 1		1000	5:51 P.M.
	Examii	ner	4a. Facility Name (If not institution, give	street and number)				4b. City, Town, or	Location of Death	4c. County	of Death	
_			13713 CECIL AVENU				If I I a day of Second	CRESAPTO		ALLE	GANY	
	Funeral Director		214-07-0030	144 -01-	e (In yrs. i	last birthday) Yrs.	If Under 1 Ye Months Day			309	9. Birthpla Country	v). W . VA .
	ryland		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				100	d. Inside City Limits
	ath with the Marylar 23a or 28a-f show	cto	MARYLAND ALLEGA	NY	CR	ESAPTO	ΝN					1 ☐ Yes 2√√No
	\$ 9 K	Dire	10e. Street and Number				10f. Zip Code		1	0g. Citizen of \	What Country	y?
	23a	ā	13713 CECIL AVENUE					502		U.S.	Α.	
0200-91212	72 hours after death with the Maryland "natures", or items 23a or 28a-f show edical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	Ever In U, lo	į.	Vas Decedent of Yes, specify C	of Hispanlc Orlgin? (uban, Mexican, Pue No Specify:	Specify Yes or No- rto Rican, etc.)		e - Americer ck, White, et y: WHIT	c.
2	72 ho	Completed	15. Decedent's Edu (Specify only highest gred	cation e completed)		16a. Deced	ent's Usual Occ	cupation	orkina	16b. Kind of B	usiness/Indu	stry
7	within iene. than	dr	Elementary/Secondary (0-12)	College (1-4or 5	+)			ne during most of wo ired)	nang .			
7 0	filed within Hygiene. rther than	S	8		·-	HOUSE	KEEPER				USE KE	EEPER
yland	2 2 2 2	To Be	17. Father's Name (First, Middle, Last) HARRY O. MORRIS						nme (First, Middle, I NNE THORN		ne)	
, mar	ind 2 : eith ar 27 is ir treu		19e. Informant's Name/Relationship (Ty EDDIE MORRIS	pe, Print) NEPHEW				eet a <i>nd Number or F</i> AVENUE CR				code) .502
ore o	- 1 2 2		20a. Method of Disposition		20b. Pl	lece of Dispos	ition (Name of atory or other p	olace)	Date	20c. Location -	City or Town	n, State
Ĕ	Pages nent of I int: If Ite		Marial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		-		RK MAY 5,	1997	CUMBERL.	AND MA	ARYLAND
Baltimor	permit. Pages Department of Important: If It eny injury or o		21. Signature of Funeral Service Licear	" SH		ME	Α_ΤΤΤΤΟ	dress of Facility DAMS FUNE	RAL HOME			
	Physician /Medical Examiner	Je.	23a. Pert1. Enter the disease, or combishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in deeth)	Mei	TAS)		CA	RE INDAM			!	Approximate noticerval Between onset and Death
	icete be executed physician and s the burief-transit	Examiner	Sequentially list conditions, if any, leading to immediate)	Due to (or	as a consequ	uence of):				1	
08/00,	sician buriel		ceuse. Enter Underlying Cause (Disease or injury that initieted events									
	THE DO	Medicai	resulting In death) Last		or or euc	as a consequ	ence of):					
. DOX	death e atte	Physician/	Part II. Other algnificant conditions con		it not resu	ilting In the un	derlying ceuse	given in Part I.	23b, Did to	bacco uae co	ntributa to ti	he cause of death?
5	that tha ed by th detache	Phy	Hypertension.						1 □ Y	es 2 No	3 Probe	bly 4 Unknown
coras,	requires t	d by	/			1			24a. Was a	o autoneu	24h Were	autopsy findings
Ö	w requ	lete							perform		comp	able prior to pletion of cause
Ď,	Physician: Tha iaw i this certificate hes b ral director, paga 2 sl	Completed							1□ Ye	s 2 No	of de	Yes 2□ No
		BeC	25. Was case referred to medical					26. Place of De	eath (Check only on	- 1		
	Physician: rthis certific rrai director,	To	examiner? 1 Yes 2 No	lospital:	nt 2 🗆 !	ER/Outpatient	3E DOA	Other: 4 Nursing		ence 6 Oth	er (Specify)	
IVISION OF	nding Ph tth. :: After th e funeral		27. Menner of Deeth 1 Naturel 5 Pending 2 Accident Investigation	28a. Date of Injur (Month, Day	Y Year)	28b. Time of Injury	28c. In		28d. Describe ho			
DIVIS	or Atter efter des Director	Certification:	3 Sulcide 6 Could not be determined	28e. Place of Injubuilding, etc	ry - At ho	me, farm, stre	et, factory, offic	ce	28f. Location (St City or Town		per or Rural F	Route Number,
	To the Hospital or Attending Physician: within 24 hours effer death. *To the Funerel Director: Affer this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of er: On the basis of end manner sta	examinati	vledge, death ion and/or Inve	occurred at the	time, date and plac y opinion, deeth occ	e, and due to the ca urred at the time, d	ause(s) and ma ate end plece,	nner as stat	ed. ne ceuse(s)
	omple	Mec	29b. Signature and title of certifier	ond mainer sta	.ou.		29c. Lice	ense number	2	9d. Date signe	d (Month, Da	ıy, Year)
	70		> 7tsw					26907		MAY 02		
	468		30. Neme and address of person who co				rint)					
			SIDHU, HARJIT, M.	D. 925 BI	SHOP	WALSH	ROAD C	UMBERLAND	, MD. 21	502		

Registrar

State of Maryland / Department of Health and Mental Hygiene 97

14623

						Ce	rtificate	e of	Death			Reg. No.			las V
1			1. Decedent's Neme (First, Middle,	Last)		1.0					2. Date of De	eath		3. Time o	of Death
	Physici /Modi		RICHARD ELMER S	CHELL							APRII	23 Day	1997	7:39	P.M.
	/Medi Examir		4a. Facility Name (If not institution,		ımber)				4b. City, To	own, or L	ocation of Deel		nty of Deeth	1.37	1 .11.
7	=		MALCOLM GROW ME	DICAL CH	ENTER				CAMP	SPRI	NGS	PRIN	CE GEO	ORGES	
	Funerai Director		5. Social Security Number 190–32–2187	8. Sex 17∑M 2□ F	7. Age (In yrs. 56	last birthday) Yrs.	If Under Months	1 Year		24 Hrs. Min.	8. Date of Bi	rth a <i>y, Year</i>)	9. Birthp Cour	place (State	or Foreign
Н			Usual Residence of Decedent								Warch	23,1941		PA	
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	10d. Inside C	Ity Limits
	Me Sel	tor	Maryland Prince	George's	5	Clint	on							1 🗆 Yes	2 No
	or 28	Director	10e. Street end Number				10f. Zip					10g. Citizen o	f Whet Cour	ntry?	
	th wi	<u>a</u>	6005 Armor Di	rive				207	735			U.S.	A.		
	ems ems	Funeral	11. Marital Stetus	12. Was Dec	cedent Ever In U, orces?		Was Decede	ent of	Hispanic Or	lgin? (Sp	ecify Yes or No Rican, etc.)		ace - Americ		
21215-0020	within 72 hours efter deeth with the Maryland ene, than "natural", or items 23a or 28a-f show the Medical Examinet must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	d 1 TYes If Yes, G Year or I	2 □ No ive		1□Yes 2	37			t mount, otoly	Spec	Whi		
5-6	72 h natu	Completed	15. Decedent's (Specify only highest	Education grade completed		16a. Dece	dent's Usual	Occu k done	pation during mos	at of work	ina	16b. Kind of	Business/in	dustry	
121	ithin ne.	ηbį	Elementary/Secondary (0-12)		1-4or 5+)				during mos	. 0	y	Privat	o Duan		
	filed with Hyglene. Ither than					Purc	hasin	g A	T		T-21 - 12/91/			mess	
Maryland	should be find Mental H marked off	To Be	17. Father's Name (First, Middle, Li Fred	Schel	L1				18. Moth		e (First, Middl€	Blair			
	2 sh end is m		19e. Informant's Name/Reletionshi Pamela Schell	(Wife)		19b. Meilir 6005	ng Address Armor	(Stree	ot and Numb	er or Aur Lint	on, Mai	per, City or Tow Cyland	20735	Code)	
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☼ Cremation 3			lace of Dispo	sition (Nam	e of her pla	ace) An	ril	28,	20c. Location	n - City or To	own, Stete	
Ĕ	Part of the		4 Donetion 5 Other (Spe			. Crema	tory		1-12		997	Clint	on. Ma	arvlar	d
alt	permit. Page Depertment of Important: If any Injury or once.		21. Signature of Funeral Service Li	cei see		22	. Name end	Addr	ess of Facili			ral Hom			
m	88 5 8		15455	#								Rd Cli			735
			23a. Part1. Enter the disease, or c shock, or heart faiture. List or	omplications that	caused the deeth	n. Do not ent	er the mode	of dy	ing, such es	cerdiac	or respiratory a	arrest,		Approxima Interval Be	te
	Physician /Medical Examiner	ler	Immediate Cause (Final disease or condition resulting in death)	-		r es a consec	uence of):	FAR	CTION				1	Onset end	Death
	uted d ansit	Examiner	Constant the Heat and distance	b	ARDIOGE.		,			-			i		
68760,	eath certificate be executed ettending physician end for use es the buriel-transit		Sequentiatly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or trijury that initiated events	c		r as a conseq									
X	0 2 9	an/Medical	resulting In death) Lest	d			_								
B.	that the death led by the etter deteched for u	Physician	Part II. Other significant condition	contributing to d	eath but not resu	ulting in the u	nderlying ce	use g	iven in Part	l.	23b. Dld	tobecco use d	contribute to	the cause	of death?
P.0	by the de	h					, -					Yes 2 No			
Ś	s that gned t	by	RENAL INSUFFI	CLENCY		_		-							
Record	law requires es been sign 2 should be	Completed	HYPERKALEMIA	<u>.</u>								an autopsy ormed?	av co	ere autopsy ailable prior impletion of death?	to
æ	0 - 0	EO									10	Yes 2 No		☐Yes 2□) No
of Vital	certificate	0	25. Wes cese referred to medical						26 Place	a of Deat	h (Check only			3 100 EC	
>		To B	examiner? 1XX Yes 2 ☐ No	Hospital:	Inpatient 2X	ER/Outpatien	t 3 DO/	Ot	hor			idence 6 🗆 O	ther (Specif	5v)	
			27. Manner of Death	28a. Dete	of Injury	28b. Time of		c. Inju				how Injury occi		<i>y</i> /	
Division	Attending I or death. Octor: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investiga		th, Day Year)	Injury	м		Yes 2□	No					
Vis		tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place	of Injury - At ho		eet, factory,	office				Street and Nun	n <i>ber</i> or Rure	A Route Nun	nber,
Ö	s efte	Seri	4 Difficial	build	ing, etc. (Specify	"					City of To	wn, State)			
	To the Hospital or within 24 hours efter To the Funeral Director completely filled in	edical (29a. Certifler (Chack only 2D Medical Ex	Physician: To the minor: On the b and man	best of my know asis of examinat mer stated.	wledge, deeth ion and/or Inv	occurred a restigation, l	t the ti	ime, dete en opinion, des	d place, th occur	and due to the red at the time,	cause(s) end r dete and place	nanner as s e, and due to	teted. the ceuse(s)
	vithin 2 To the	M	29b. Signature and title of certifier	1 /			29c.	Licen	se number			29d. Date sign	ned (Month,	Day, Year)	
			· 1/2 1000	Ч				677	796E C	A		APRIL	23,199	97	
			JOHN K. WALL.C 1050 W. PERIME	TER RD S	UITE CI-	-/ AND	Print) REWS_A	AFB	MD 20	0762-	-6600				
	Sta Registr	te ar	31. Date filed (Month, Day, Year) APR 3 0	1997 32. F	Registrer's Signat	ture West-Ray	dall								



State of Maryland / Department of Health and Mental Hygiene

14624

						ate of	Dealli		Reg. No.		
Physici /Medi		Decedent's Nama (First, Middla	John John	Н.	SWA	USON		2. Date of De Month		1997	3. Time of Death
Examir		4a. Facility Name (If not institution,	giva street and number	er)	- will		lb. City, Town, o	r Location of Deat	h 4c. Cou	nty of Death	///
LXaiiiii	ICI	PENINSULA REGIO	MAI MEDICA	I CENTE	ים		SALIS	עמוום		ICOMIC	2
Funeral		5. Social Security Number		Age (In yrs. last	birthday) If U	ndar 1 Yaar	If Under 24 Hi	s. 8. Date of Bi	rth	-	
Director		578-20-9523	1 ∑ M 2□ F	77	Yrs. Mon	hs Days	Hours Mi	r. (Month, Di	av. Year)	Washi	ace (Stata or Forei ry) .ngton,D.
		Usual Residence of Dacadent						100.0	, 1) 2 0	Madii	ing con, b.
r 28a-f show		10a. Stata 10b. County		10c. City, To	own or Location				_	10	d. Inside City Limi
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	/Medi Examii		4e. Facility Neme (If not institution, give straat and number)					4b. City, Town, or Location of					
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	pue *		Usual Residence of Decedent 10e. Stete 10b. County		10c. City, Town or Location 10d. inside City Limits						Od incide City Limite		
	Manyi	0	Maryland Wicomic	isbury						1⊠ Yes 2□ No			
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the 12 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of V	What Coun	trv?	
			1016 Begglin Park Dr.				21804			US			
, Maryland 21215-0020		Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Detes:		Ever in U,S.	13. W		lispenic Origin? (S an, Mexican, Puer	pecify Yas or No		a - America		
	ours after	by			lo		☐ Yes 2 No			Bleck, White, etc. Specify: white			
	vithin 72 ho ne. han "natur ned cal	Completed	15. Decedent's Education (Specify only highest grade completed)			16e. Decedent's Usual Occupation (Give kind of work done during most of workin			rking	16b. Kind of Bu	usiness/Ind	ustry	
		mpie	Elementery/Secondary (0-12) College (1-4or 5+)				life. DO NOT use retired)						
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	and 2 alth a 27 is		Everett T. Ellis	- son								ry, Md.2180	
ore	permit. Pages 1 and 2 Department of Health 1 Important: If item 27 is any Injury or other tra		20e. Method of Disposition		20b. Plece o	of Disposi	ition (Name of etory or other ple	ce)	Date 05/02/97	20c. Location -	City or To	vn, State	
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Ball	Departi Departi Importi any inj once.		21. Scriature of Fundal Service Cleans 22. Nama and Address of Facility Cranston Funeral Home										
	205 a d		John A. Cranston P O Box 967, Seaford, DE. 19973										
	Physician /Medical Examiner	Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)	b	Dua to (or es e	consequ	enca orj.	UCTIVE	PULMOR	ARY D	SEASE	YEARS	
Box 68760,	icate be executed physician and sthe buriel-transit	edicai Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Ceuse (Disease or injury that initiated events cause) and the consequence of the c										
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the bunel-transit	by Physician/M	resulting in deeth) Lest	d	70a to (01 6 5 6	conseque	arios ory.						
n n	death		Pert II. Other significant conditions co	ntributing to death bu	t not resulting i	in the und	lerlying cause giv	en in Pert I.	23b. Did t	obacco use cor	ntribute to	the cause of death?	
0.	v requires that the de been signed by the should be detached		HYPERKALEMIA BREAST CANCER ATRIAL 1/198 2/No 3/Probably 4/Unk FIBRILLATION, CORDNARY ARTERY DISEASES 248. Was an autopsy performed? CARPIOMYOPHTMY, CONGESTIVE HEART FAILURE 1/198 2/No 3/Probably 4/Unk 24b. Were autopsy findir evallable prior to completion of cause of death?							ably 4 Unknown			
Š	signe bed		MYPERRALED	LIA , ISI	SEA31		HUCER /	HIRIAL					
IVISION OF VITAL H	requi	etec	TIBRILLA	rion ,	CORONA	try	ARTER	YUSERS	24e. Wes	en eutopsy med?	949	re eutopsy findings ileble prior to apletion of cause	
	sician: The law certificate has t irector, page 2 s	Completed	CARPIONY	OPHTNY,	CONG	EST	IVE HE	PART FAIL	URE	es 2000	of d	eath?	
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	ing P	Certification:	27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of injury et Work? 28d. Describe how Injury occurred Work?										
	To the Heaptal or Attending Phys within 24 hours effer death. To the Funeral Director: Affer this completely filled in by the funeral dir	icat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined editermined 28e. Place of Injury - At home, ferm, street, factory, office 28f. Location (Street end Number or Rural Route Number,										
		ertit	4 Homicide determined	building, etc.		erm, stree	it, rectory, office		City or Tow		gr or Hurai	Houte Number,	
		edicai C	29a. Certifier (Check only one) 29a Wedical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end manner as stated.										
		Me	29b. Signetura and title of cartifigra	end menner stet	/		29c. Licens	e number		29d. Date signed	1 (Month, C	Jey, Year)	
			I Rula for Trust				036576			4/27/87			
		+	30. Name and address of person who co	empleted cause of de	eth (Item 23a)	(Type, Pr							
			RONALD P	. TRAVET	2_40	560	DRIVE	RSIDE D	R SALL	SOURY !	MD 2	1001	
	Sta Registra	te ar	30. Name and address of person who or Rounce P 31. Dete filed (Month APR 279 19)	97 32 Augustra	le Signature	Cardal	6						

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month 0 4 **Physician** 0445 SALTERBACH Corinne 26 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic Berlin Worcester General Hospital If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) **Funeral** Deys 1 □ M 2 Ø F Months Hours Min 127-14-8860 75 Director March 6,1922 New Jersey Usuel Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland next of Health and Mental Hyglene. Intel if it is a 23a or 28e-f show mit: if item 27 is marked other than "natural", or items 23a or 28e-f show any or other traumatic event, the Medical Experimer must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1K Yes 2 No Director Maryland Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 510A. Georgia Avenue 21801 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No 1 № Never Merried 2 Merried altimore. Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White ò 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grede completed) 18a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. Supervisor Mutual of New York 17. Father'a Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Louis Ρ. Salterbach Burkhard Corinne 2 19a Informant's Name/Relationship (Type Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 W. Schumaker Manor, Salisbury, MD 21804 Augusta Heath/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other placa) 20c. Location - City or Town, State Date 1 ☐ Buriai 2 ☑Cremetion 3 ☐Removal from State Department of important: If any injury or page. 4 ☐ Donation 5 ☐ Other (Specify) 4/26/97 Salisbury, MD Salisbury Crematory 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility M0/05/ Holloway Funeral Home avid Domoso 501 Snow Hill Rd., Salisbury. MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) a Carcinoma of Examiner Due to (or as a consequence of) Examiner ettending physician and for use as the buriei-transit lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): signed by the eld be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à Completed 24a. Was an autopsy performed? 24b. Were autopsy findings avellable prior to completion of cause of death? has page 2 certificate 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physicien: 24 hours after death. Funeral Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ၉ 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Inneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 12 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical 29b. Signature end title of portillo 29c. License number 29d. Date signed (Month, Day, Year) 00050605. APRIL D Ms 30. Name and address of person who completed cause of death (them 23a) (Type, Print)
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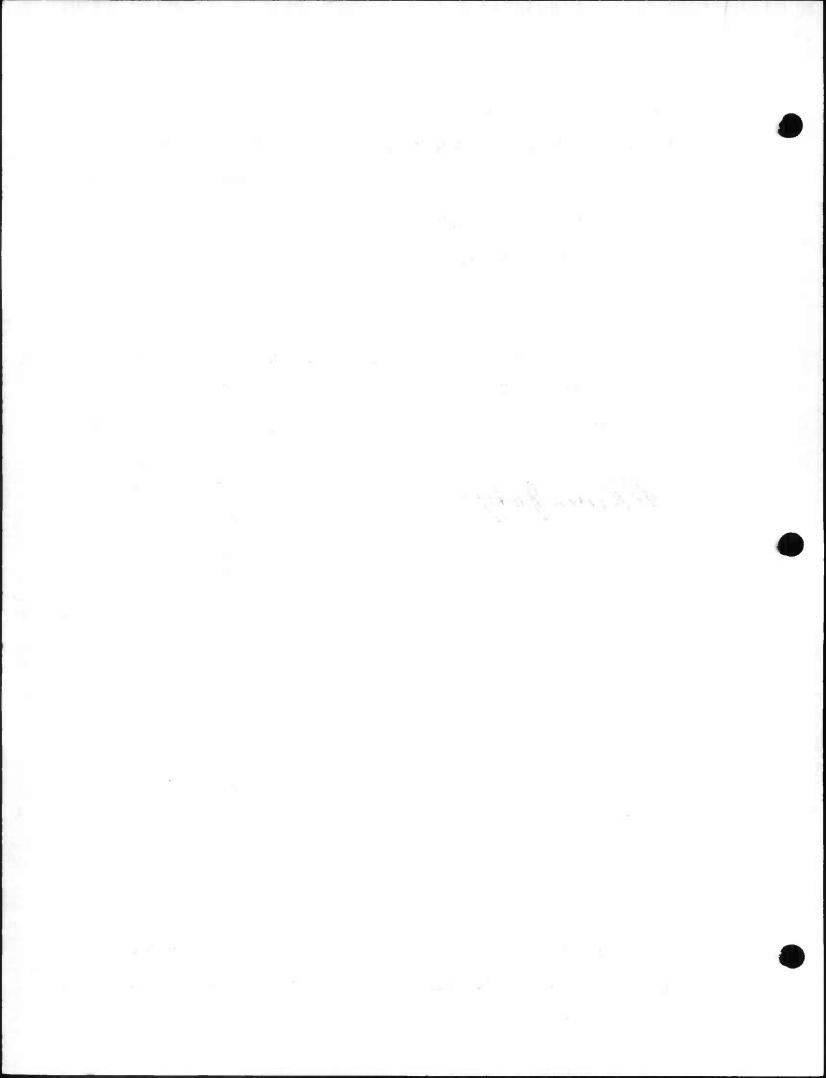
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4629 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth harlotte Silbernage Marie Apri 1997 10:52 PM 4e. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Deeth Fallston General Hospital Fallston Harford If Under 1 Yeer If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Dete of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country) Deys 1□ M 2XF Yrs 212-07-0469 Sept. 15, 1917 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inelde City Limits Maryland Harford Edgewood 1 Yes 2 No 10e. Sfreet end Number 10f. Zlp Coda 10g. Citizen of What Country? 2001 A. Pulaski Highway 21040 TISA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1□ Yes 2HNo Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Head Librarian U.S. Government 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Sumeme) Walter William Pieper Barbara Anne Miller 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Bonnie Marzicola 2001 Pulaski Highway, Edgewood, MD 20e. Method of Disposition ▼Buriei 2 □ Cremetion 3 □ Removel from State 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stefe Dete 4 ☐ Donetion 5 ☐ Other (Specify) Spesutia Cemetery 4-14-97 Perryman, Maryland 22. Neme and Address of Fecility HOWard K. McComas III Funeral Home, P.A. allemas. 1317 Cokesbury Road, Abingdon, MD 21009 the List only one cause on each line. Approximete Intervel Between Onsef and Death Immediata Ceusa (Finei disease or condition resulting In deeth) Dua to (or as e consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Causa (Diseese or Injury that initiated avants resulting In deeth) Lest Due to (or es a consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the undarlying ceusa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown Obstructive Pulmonary Disease 1 Yee 2 No 24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 24e. Wes en eutopsy performed? Aspiration Preumonia 1 ☐ Yes 2 ☐ No 25. Wes cese raferred to medical axaminer? 26. Pieca of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA

Physician /Medical Examiner

Physician

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Director

Funeral

by

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tra Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mantal Hydraen. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic avant

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760.

Division of Vital

the Manyland

Examiner Physician/Medical Completed by Be Certification: To

physicien and s the buriel-transit To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p.

been signed t should be det page 2

edical

27. Mannar of Death 1 Neturel 2 Accident 3 Sulcide 4 Homicide

29a. Certifier

5 Pending

investigation 6 Could not be detarmined

Hospitei: 1 Inpatient

28b. Time of

28e. Piece of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the bast of my knowledge, death occurred et the time, date end piece, and due to the cause(e) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) end manner stated.

29b. Signature end fitte of certifier

29c. License number drew Novalernslam Dogo86

29d. Dete signed (Month, Day, Year)

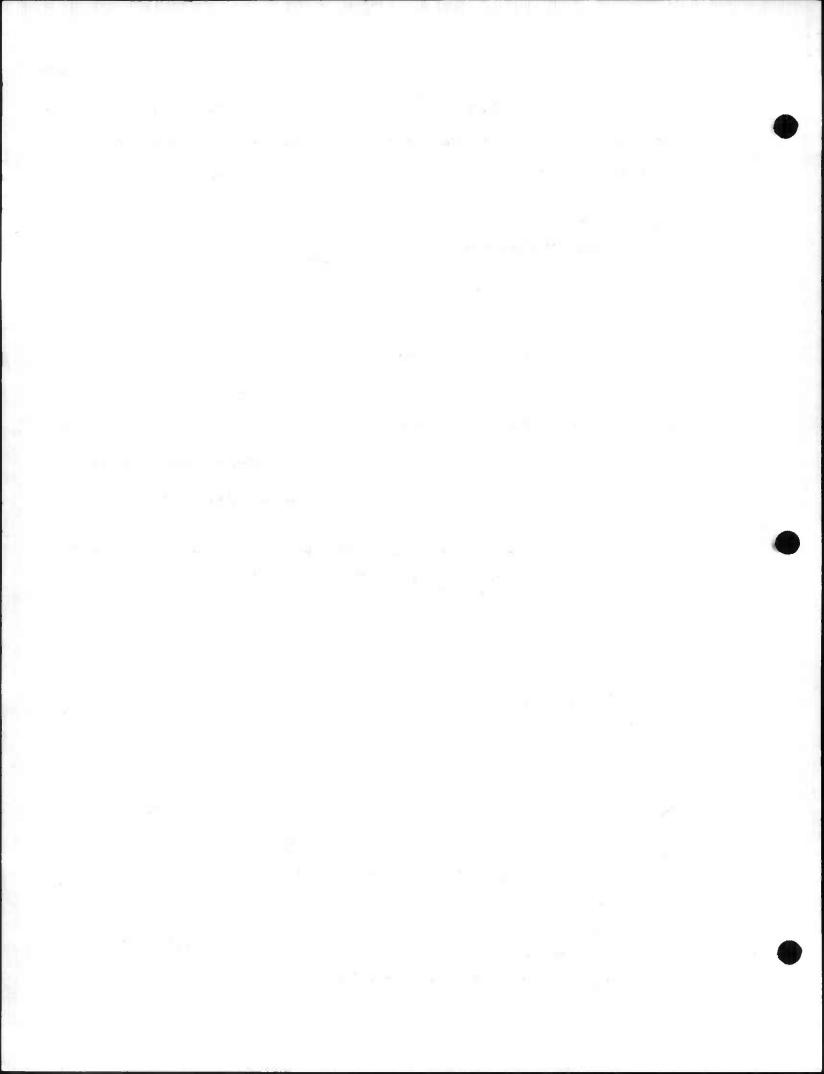
30. Nema and eddress of person who complated ceuse of deeth (item 23a) (Type, Print) 125 N. MAIN St. BEI Air, MP

NOWAICOWSKI

State Registrar State of Maryland / Department of Health and Mental Hygiene

						(Certificate	of Death		eg. No.	1	14630		
	Physici		1. Decedent's Nama (First, Middle Ronald Haro		nurg				2. Data of Deal Month April	h 29 1997	Year	3. Tima of Death 10:30PM		
	/Medic Examir		4a. Facility Nama (If not institution				-	4b. City, Town, o	or Location of Daeth	4c. County	of Death	10.30FH		
			Parking lot i	n front o	of 2	Powe11s	Lane	Frostbu	rg	Alleg	any			
	Funeral Director		5. Social Sacurity Number 220-58-0462 Usuel Rasidanca of Dacedenf	6. Sex 1 M 2 □ F		In yrs. lest birthe	Months D	ear If Under 24 H ays Hours Mi			9. Birthp Cour Maryle	lace (Stata or Foreig try) and		
	yland		10e. Siete 10b. County		1	0c. City, Town	r Location				1	0d. Insida City Limits		
	e Mer	ctor	Maryland Alle	gany		Frostburg) Section					1 Nes 2 No		
	vith th	Director	10e. Street and Number 246 W	. Mechanic	Stree	t	10f. Zip Co	de	1	0g. Citizen of W	hat Cour	itry?		
	eath v	erai	11. Marital Status	12. Was Dece	dont Ev	or in II S		1532-	(Carait, Van antia	U.S.A		an Indian,		
0700-61717	J within 72 hours after death with the Meryland jiane. Than "natural", or Items 23a or 28a-f show the Medcel Examiner must be notified at	by Funeral	1 Navar Married 2 Marri 3 Widowed 4 Divorced	Armed Fo	rces? 2 No /a	ar #1 0,3.	If Yas, specify		(Specify Yes or No- arto Rican, atc.)		k, Whita,	atc.		
<u>-</u> -	72 ho natur	Completed	15. Decedant (Specify only highas	's Education t grade complated)		16a. D	ecedant's Usual O	ccupation ona during most of и tired)	rorking	16b. Kind of Bu				
7	within ane. than	jdwc	Elamantary/Secondary (0-12)	Collaga (1	-4or 5+)					State Government				
A	Hygi ther mt, n		17. Father's Nama (First, Middle, I	Lest)		nou	sekeabilið	Department 18. Mothar's N	ama (First, Middla, I			21 H		
2	D = D ·	To Be	Harold C. Schurg					Evel	yn Buskirk					
Maryland	and series		19a. Informant's Name/Ralationsh	nlp (Type, Print)		19b. N	lailing Address (St		Rural Route Number	City or Town,	Stata, Zip	Coda)		
	other tre		Rosemary Schurg	Wife			t Mechanic	Street Fros	trburg		Maryland 21532- Location - City or Town, Stata			
7	00		20a. Mathod of Disposition 1		Stata		isposition (Nama c cremetory or othar	_						
	그 든 큰 글		4 ☐ Donation 5 ☐ Other (Sp 21. Signafura of Funeral Service L			Frostb	urg Memoria! 22. Nama and A		-May-97	Frostburg,	Mary	land		
Š	Depa Impo any ir		1 John R	Werest				•	7 Frost Ave.,	Frostburg	MD	21532		
			23a Part. Enter tha disaase, or a mack, or heert failura. List of	complications that c	aused the	a daath. Do not					1	Approximata		
-	Physician (Medical			one oddae on a	don into.							Interval Batween Onsat and Deeth		
	/Medical Examiner		Immediate Causa (Final disease or condition resulting in death) Self inflicted gun shot wound to the head situation and the self inflicted gun shot wound to the self inflicted gun shot wound to the self inflicted gun shot wound to the self inflicted gun shot wound to the self inflicted gun shot wound to											
		Jer		-				mixed di	sturbance	of				
	cuted nd ransit	Examiner	Sequentially list conditions.	b. emoti		and cor				_	u	k yrs		
Š	e axe		Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that Initieted avants											
50.00	tificete be axecuted ng physician and es the bunal-transit	edicai	that initieted avants rasulting in daath) Lest	C	Due	e to (or as a cor	sequanca of):							
	5 00			d										
Y .	death cert a attendin of for use	sicia	Part It. Other significent condition	ns contributing to de	ath but n	not resulting in th	e undartvino ceus	oivan in Part I	23b. Did to	bacco use con	tribute to	the cause of death		
٥, ٦, ٥	requires that tha death cer been signed by tha attendir hould be detached for use	by Physician/M	A nti socia								3 □ Prol	\ /		
5	v require been si should								24a. Was a parform		eva	are autopsy findings allabla prior to		
necolds,	The law are has be pega 2 sl	Completed			_				-	V		mpletion of causa death?		
2			OF Man once referred to modical						1 □ Yε		1 [Yas 2 No		
	Physician: rthis certific rral director,	o Be	25. Was case refarred to medical examinar? Yes 2 No	Hospital:	npatiant	2 □ EB/Outo	itient 3 DOA		eath (Check only on Homa 5 - Reside		r (Specif	pk lot		
5	ding Phy h. Aftar thi funerai	T:U	27. Menner of Death	28a. Deta		28b. Tim		njury at Work?	28d. Dascribe ho			//•		
	Attending ir daeth. ector: Aftai by the fune	Certification:	1 Natural 5 Panding 2 Accident invastig					1 Yas 2 No	sub sho					
	or Att	THE STATE OF	april 29,1997 9:47P sub shot himself Sub shot himself 2 Accident Sub shot himself 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) Parking for the parking for t											
	To the Hospital or Attending within 24 hours after daeth. To the Funeral Director: After completely filled in by the fune		29a. Certifiar 1□ Certifying						2 Powe1					
	Me Hos	edicai		xaminer: On the ba	isls of ax	aminetion and/o	r Invastigation, In r	ny opinion, death oc	curred et the tima, de	ite end place, a	nd dua to	tha cause(s)		
	within To th	Me	29b. Signature and title of partities	/			29c. Lic	ansa numbar	2	d. Data signed	(Month,	Day, Yeer)		
	6		(Bel /					D 09157	A	pril 29	199	7		
	na)		30. Name and address of person w	no completed caus	e of deet	h (Item 23a) (Ty	pe, Print)							
	100		Paul Chorr M	1 7/1 vv	drd -	et Cumb	Md 21502							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Vaar WILLIAM Jr. APRIL 2:52 A.M. SCHAIDT 30 1997 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year)
Jan. 7, 1940 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1√2 M 2□ F Days 57 220-38-0694 Yrs. Maryland Usual Rasidence of Dacadani 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Allegany 1 Yas & No Lonaconing 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 35 Front St. 21539 USA 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 Navar Marriad 2 Marriad 1 Tyas 2 No HYes, Giva
Yaar or Dates: 962-1965 1□ Yas 2□ No SpecifiWhite 3 Widowad 4 Divorced 16a. Dacedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) Collega (1-4or 5+) Owner Hardware 17. Father's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Wm. G. Schaidt Sr. Mabel Wilt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Jean Schaidt-Wife 35 Front St., Lonaconing, Md. 21539 20b. Place of Disposition (Nama of comatery, cramatory or other place)

ak Hill Cemetery 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Spacify) May 2 Lonaconing, Md. 1997 21. Signatura ot Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Eichhorn-McKenzie Funeral Home Σ. ams Lonaconing, Md. 21539 Entar tha disaasa, or complications thei caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, or heart failure. List only one cause on each line. Approximata Intervel Batw Onsat and Death Immediata Causa (Final disease or condition resulting in deeth) a ACUTE INFERIOR WALL MYOCARDIAL INFARCTION 10 HOURS Dua to (or es a consaguanca of): Sequantially list conditions, if eny, laading to immediata causa. Entar Undarlying Causa (Diseese or Injury that initiated avants rasulting in daath) Last Due to (or as a consequence ot) Due to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy parformad? 1 Yas 2 No 1 ☐ Yas 2 No 25. Was case ratarrad to medical axaminer? 26. Placa of Daath (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

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Director

Funeral

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Completed

traumatic event, the Medical Examiner must be notified at

with the Marylend

death Herne

filed within 72 hours efter

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiering important: If Item 27 is marked other than any Injury or other traumetic content than

Baltimore, Maryland 21215-0020

/Medical

10a State

11. Marital Status

ettending physician for use es the burie the 5 á signed t peeu hes pege 2

P.O. Box 68760,

Records,

Division of Vital

that the death certificate be executed certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

Physician/Medical þ Completed Be Medical Certification: To

8

29b. Signatura and titla of cartifiar tuch

5 Pending invastigation

6 Could not ba datarmined

1 ☐ Yes 2 No

27. Mennar ot Daath

1 Naturel

2 Accident 3 Sulcida

4 Homicida

29a, Cartifian

28a. Dete of Injury (Month, Dev Year)

Impatiant 2 ER/Outpatient 3 DOA

28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify)

28b. Tima of

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basts of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa numbar 29d. Data signad (Month, Day, Year)

28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

APRIL 30 1997

30. Nama and addrass of person who complated cause of death (Itam 23a) (Type, Print)

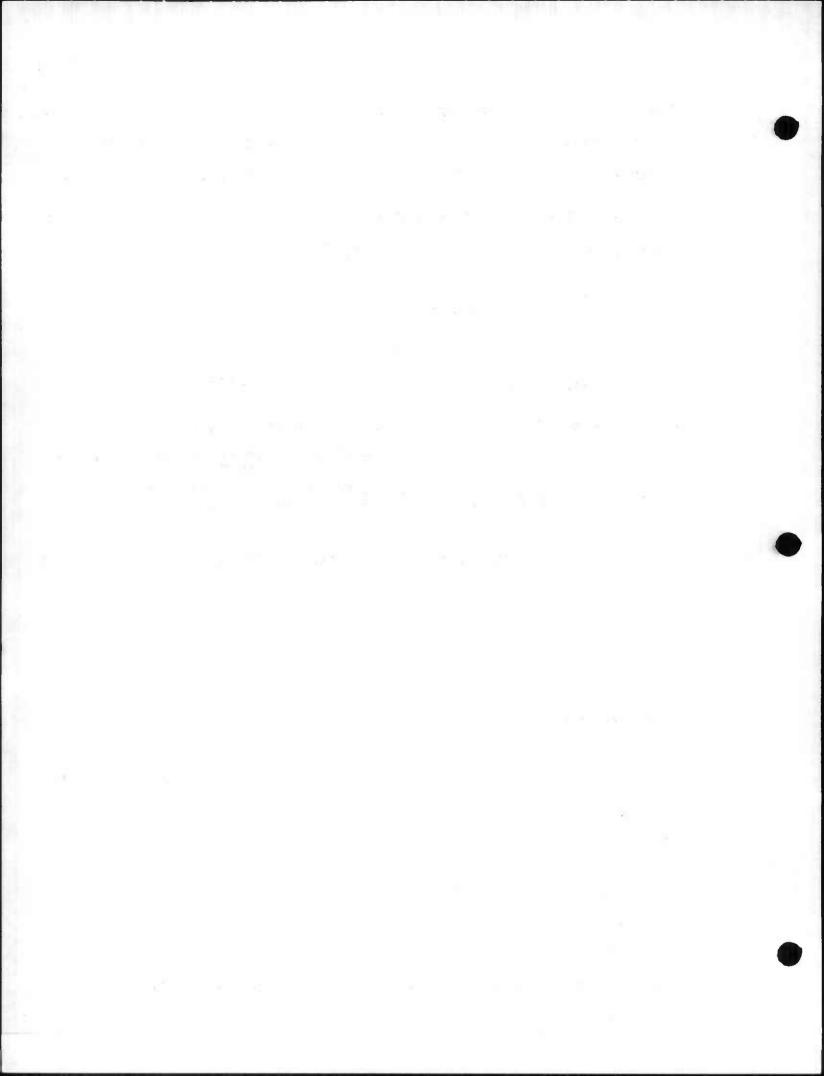
ROBUSTIANO BARRERA M.D. MEMORIAL HOSPITAL MEDICAL BLDG. CUMBERLAND, MD 21502 31. Date tiled (Month, Day, Year)

28c. Injury at Work?

D 14865

1 Yes 2 No

State Registrar 32. Registrar's Signatura



Gary Allea Stotler more, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month De April 27 **Physician** GARY ALAN STOTLER 7:41 pm /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1X M 2□ F Months 43 Yrs. 547883144 Director Nov 20 1953 Germany 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Manylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other thaumatic event, the Medical Examination must be not ited. 10d. Inside City Limits MD No Yes 2 No Director PRINCE GEORGES NEW CARROLLTON 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 6521 JODIE ST USA 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yas 2 ☐ No 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) CARPENTER CONSTRUCTION 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middla, Maldan Sumama) EARL LESLIE STOTLER. SR AGNES LORRATNE BEACH 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 5355 SATTERFIELD CT STEVE JEWETT WOODBRIDGE VA 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 X Removal from State Cumberland Valley Crematorium 4/30/97 Waynesboro PA 17268 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Addrass of Facility Grove Funeral Home, Inc. 50 S Broad ST Waynesboro PA 17268 Joulerson se, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only ona ceuse on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Ceuse (Finel Congestive Heart failure involles disaasa or condition resulting in death) Examiner Due to (or es e consequence of) Cardia tomplant mulles the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Cardiac Ischemia Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Vinknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate has 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifics completally filled in by the funeral director; Be 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Medicai Certification: 5 Pending investigation 1 Naturei 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier to Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner es stated.

Madical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated. (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year)

DR. STEVEN REMDEN, CEA 575 MAIN STREET, SUITE 355, LAUREL, MD 20707

State Registrar A feer Recurs MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

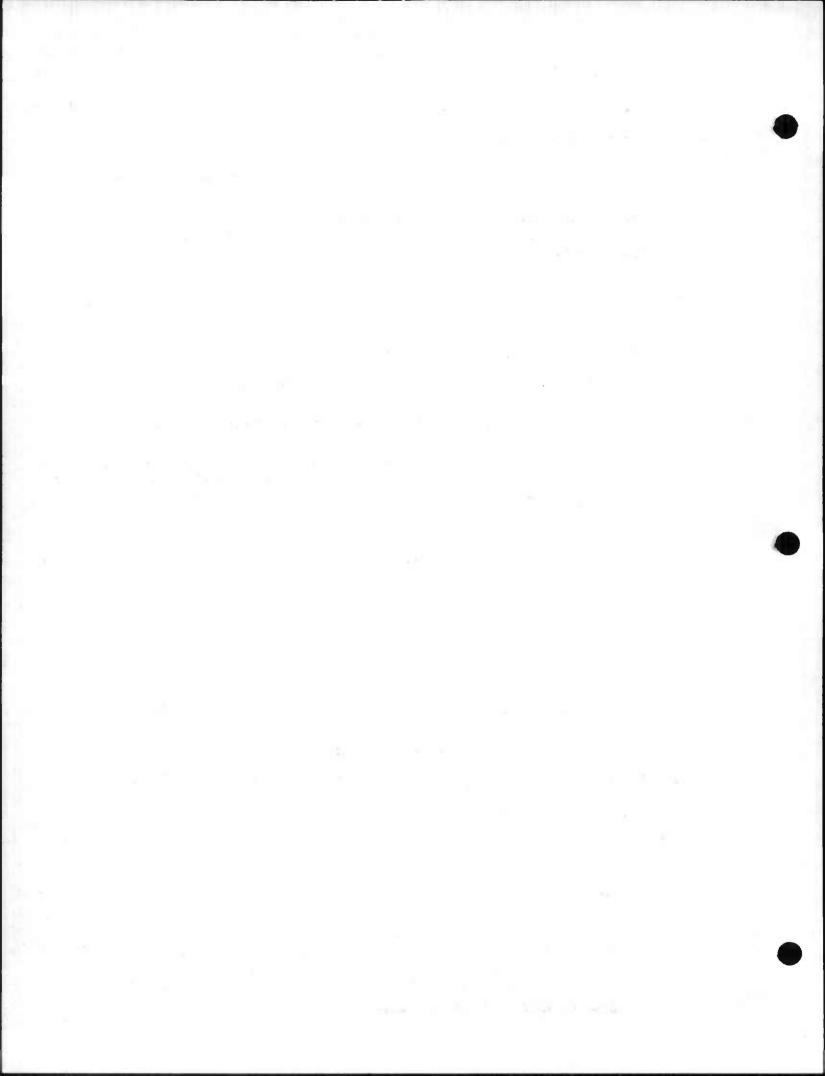
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Myrtle 1:38 pm Irene April Swartz 29 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington country Hospital Itayerstown washington 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1□ M 210 F Months Days Hours Yrs. 214-09-5392 Director 81 Jan. 14, 1916 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner, must be notified at 1⊠Yes 2□No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 222 Winter Street 21740 USA 11 Marital Statue 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hyglane. Important: if item 27 is merked other than "natural," or item any injury or other traumetic event, the Medical France 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 Yes 28 No Specify: Specify: 2 3₺ Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Rusiness/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 cutter clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be James Robert Alder Mary Ellen Kreps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Crabtree - daughter 222 Winter Street, Hagerstown, Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 5-1-97 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 unnect 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Mulignant Lymphona 2 7-20 Examiner Due to (or as a consequence of) Examiner shysiclan and the buriel-transit certificate be axecuted Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical Due to (or as e consequence of): 98 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown hemolytic Autoimmune Anemia Records, 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? Lerkougtopenia Renal Failure Peritonitis Supraventrialar Tachy cardia 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No this To the Hespital or Attending P? within 24 hours after death.
To the Funeral Director: After the completaly filled in by the funeral 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how Injury occurred After t 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) hllus mo April 29, 1997 046081 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

State Registrar 346 mill street



Frank J collins



State of Maryland / Department of Health and Mental Hygiene

14634

						Ce	rtificate o	f Death			Reg. No.			
	Physic /Medi		1. Decedent's Neme (First, Middle, Catherine Chami	nade San						2. Dete of De Month APRIL	Dey ZG	Year 1997	3. Time of Deeth	
j.	Exami	ner	4e. Facility Neme (If not institution,							ocation of Deet				
H	Funeral			Sing non Sex 1□M 2⊠F		s. lest birthdey) () Yrs.	If Under 1 Year Months Dey	r If Under		8. Dete of Bi	th ey, Year)	9. Birthi	g CON piece (Stete or Foreign	
	Director		217-26-5408 Usuel Residence of Decedent		0	U ris.				Dec. 13	L,1916	Man	ryland	
	show d =	-	10e. Stete 10b. County		10c. C	City, Town or Lo					-	1	10d. inside City Limits	
	W 1	Director	Maryland Washi	ngton		ная	gerstown						Yes 2□ No	
	23a or 3		10e. Street and Number 208 W. Wilson	Blvd.			10f. Zip Code		740		10g. Citizen of USA		ntry?	
	72 hours effer death with the Maryland naturel, or frems 23s or 28s-1 show deat Examiner must be notified at	by Funeral	11. Maritel Stetus 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed F	2 X No		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ No	ben, Mexicer	n, Puerto	ecity Yes or No Rican, etc.)		ce - Americ ck, White, by: W		
	within 72 hours ene. than "naturel", he Madical Ex	Completed	15. Decedent's (Specify only highest (Secondery (0-12)	rede completed)	1-4or 5+)	16e. Dece (Give life.	dent's Usuel Occ kind of work don DO NOT use retir	upetion e during mos red)	t of work	ing	16b. Kind of B	usiness/In	dustry	
i	0 0 -	Con	12	0			housewi	fe			her o	wn ho	ome	
	e de de	To Be	17. Fether's Neme (First, Middle, La Chester Leatherm	*						e (First, Middle Nunamal	, Meiden Sumer Cer	ne)		
	d z should th end Men 7 Is marke traumatic		19e. Informent's Neme/Reletionship	(Type, Print)		19b. Meili	ng Address (Stree	et and Numbe	er or Run	al Route Numb	er, City or Town	, State, Zip	Code)	
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	2 2 2		20e. Method of Disposition 1 ☑ Buriai 2 ☐ Cremetlon 3	☐Removel from		Pleca of Dispo cemetery, crea	osition (Neme of metory or other p	lece)		Date	20c. Location			
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1	nd trensit	Examiner	Sequentially list conditions,	b	Due to ((or es e consec	quence of):				24 Hour			
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	9 9 %	Physician	Pert II. Other significant conditions	contributing to d	eath but not re	sulting in the u	nderlying cause o	given in Pert I		23b. Did	tobacco use co	ontribute t	o the cause of death?	
ahea ahea	ned by detac	by Ph	ALZHEIMER'S	DE	MENT	(A)				1 🗆	Yes 2 XNo	3 ☐ Pro	bably 4 Unknow	
	s peen s	Completed b							<u>.</u>	24a. Wes	en eutopsy ormed?	av	ere autopsy findings allable prior to impletion of cause deeth?	
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2	after death Director: /	ertific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Piece	of Injury - At t ing, etc. (Spec	nome, farm, str ify)	eet, fectory, office	•		28f. Location (City or To		ber or Aura	al Route Number,	
To the Househall	within 24 hours after	edical C	29a. Certifier (Check only one) Certifying F	aminer: On the b	best of my knoesis of exemination	owledge, death etion end/or in	n occurred et the vestigetion, in my	time, date en opinion, dee	d pieca, th occurr	end due to the red et the time,	ceuse(s) and modete end plece,	anner as s and due te	tated. the ceuse(s)	
Total	within 2 To the comple	Me	29b. Signeture end title of certifier				29c. Licer	nse number			29d. Date signe	ed (Month,	Day, Yeer)	
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			30. Neme and address of person wh					, , , ,		0				
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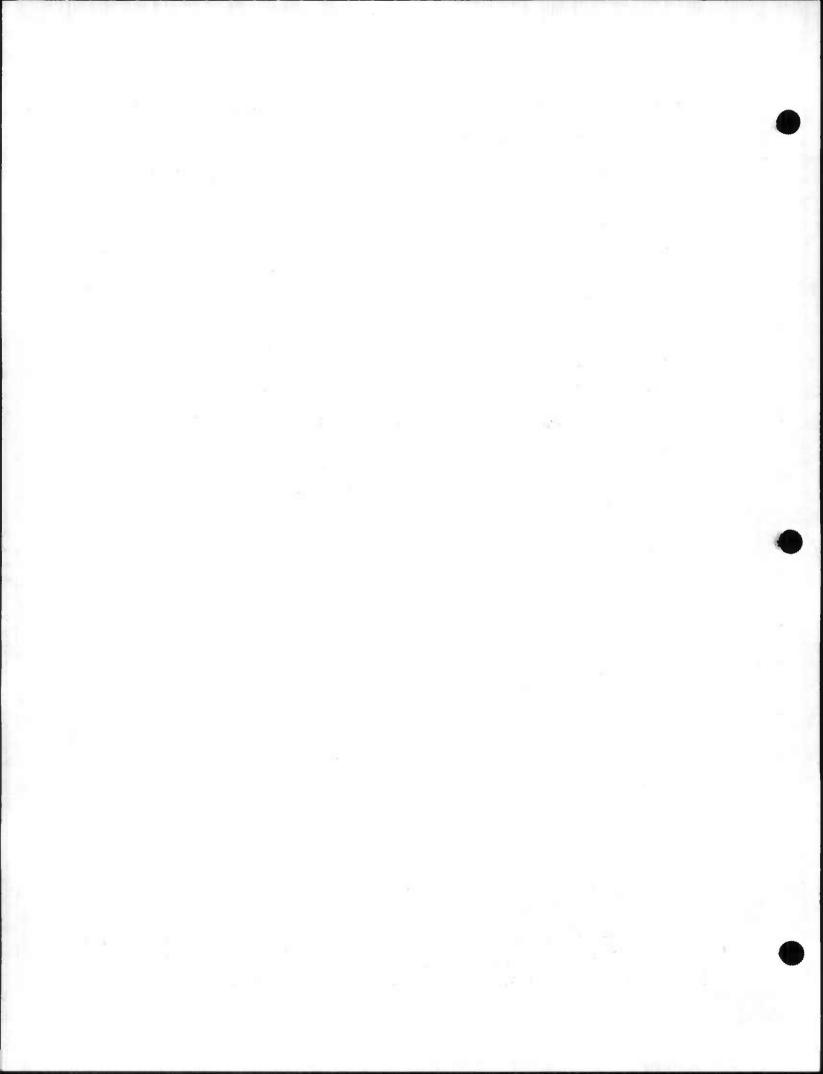
DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** Stephen Paul Tranum 11:20 PM April 21 1997 /Medicai 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Garrett Memorial Hospital Oakland Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1€M 2□ F Months Deys Hours 218-48-9662 Yrs. Director 50 Sept 28 1946 Maryland Usual Residence of Decedent nit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland administration of Health end Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23e or 28=f show injury or other traumatic event, the Medical Examine must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Md Oakland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Stanton Lane 21550 United States Funeral 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 1∑Yes 2☐No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Biack, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√ No Specify: þ If Yes, Give Year or Dates: Army Specify: White 3 Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Supervisor School System Unkmwn 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Tranum Margaret Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 East Main St, Thurmont, Md. 21788 Wendy Jones/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department of Important: If any injury or once. Philos @metery 4/24/97 Westernport, Md. 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Boal Funeral Home 111 Church St. Westernport, Md. 21562 au 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) l year liver failure Examiner Due to (or as a consequence of): Examiner years cirrhosis The law requires that the death certificete be executed ettending physician and for use es the bunat-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): acute and chronic alcoholism years Box 68760, Physician/Medical Due to (or as a consequence of): signed by the ettending d be detached for use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 708 2 No 3 Probably 4 Unknown systemic lupus erythematosis by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peed page 2 hes 2 DINO certificate 1 Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO ٩ 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: i or Attanding P efter death. I Diractor: After I d in by the funera After 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours e Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, M.D. 311 N. Fourth St Oakland, MD 21550 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Jahr Davilson Rardall AFR 2 4 1997 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 97 | 4636

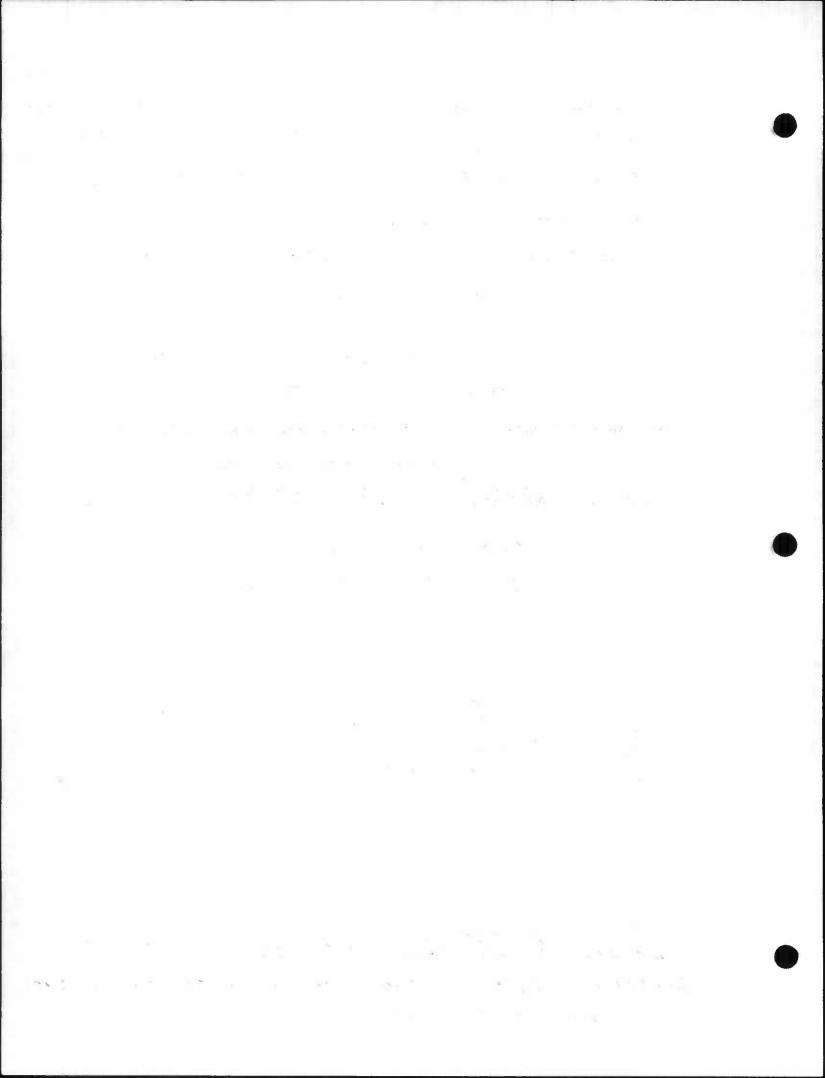
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	Exami		4a. Facility Name (If r	not institution,	give street and n	ım <i>bər)</i>				4b. City, To	wn, or L	ocation of Dea	th 4c. Co	unty of Death	
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ding Phys	eath. or: After thi the funeral			5 Pending		of injury th, Day Year)	28b. Time of injury	M 2	8c. Injun Worl	y at k? Yes 2□		28d. Describe	how injury or	curred	
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the Hospital or	within 24 hours a To the Funeral C completely filled	edicai	29a. Certifier 1 (Check only one)	Certifying i	Physician: To the aminer: On the band men	best of my know asis of examinationer stated.	riedge, death on and/or inv	occurred a estigation,	at the tim in my op	ne, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) and date and pla	manner as s ca, and due le	tated. the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 97

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	Funeral		215-48-040		□M 2⊠F		Yrs.		ays	Hours	Min.	(Month, De)	Y. Year)	9. Birth	ntry)	ete or Foreign
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	and w			o. County		10c. City,	Town or Lo	ocation						1.	10d insid	le City Limits
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8	filed within 72 hours after deeth with the Maryland Hygiene. Ifther than "naturel", or Neme 23s or 28s-f show ont, the Medical Exeminet must be notined at	by	3 ☑ Widowed 4 □	Divorced	Yeer or Detes:			103 2,00	140	орвону.			Spec	my:	White	е
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Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "naturel", or Hems 23a or 28af show important: if Item 27 is marked other than "naturel", or Hems 23a or 28af show important: or the returnation of the Medical Examiner must be notified and once.		21. Signature of Paneral	Service Licer	isee	10105	5 / 2	2. Neme end A				Uomo				
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	691		Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart teliure. List only one cause on each line. Approximate interval Betw													imete
V.	Physician	shock, or heert teilure. List only one ceuse on each line.											1		Between and Death	
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State of Maryland / Department of Health and Mental Hygiene 97

						Cei	rtificat	e of	Death			Reg. No.	1	14000		
			1. Decedant's Name (First, Middla,	Last)							2. Data of De	ath	V	3. Time of Death		
	Physic /Medi		Dorothy	Α	Thom	as					April	23 19	997	6:23PM		
	Exami		4a. Facility Name (If not Institution, Wicomico Nu						4b. City, To	wn, or L	bury	4c. County				
	Funeral Director		216-07-6312	6. Sex 1 □ M 2 1 F	7. Age (In yrs. le	ast birthday) Yrs.	If Under Months	1 Yea Days		24 Hrs. Min.	8. Data of Bir (Month, Da November	th ly, Year) 20,1909		placa (State or Foreign ntry) ryland		
	yland M M		Usual Residence of Decedent 10a. Stata 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits		
	Sa-f si	Director	Maryland Wic	omico		Hebro	n							1)€ Yes 2 No		
	a or 2		10e. Street and Number 310 Lillian St	no.o.t			10f. Zip		01000			10g. Citizen of		ntry?		
	na 23	Funeral	11. Marital Status		cedent Ever in U.S	3 13 1	Was Dacad		21830	ain2 (Sn	acifu Vas or No	US.		can Indian,		
020	72 hours after death with the Maryla natural, or litems 23s or 25s-f show dies! Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed F	Forcas? 2 □ No Sive		_		ban, Mexicar Specify:		ecify Yes or No Rican, atc.)	Bla Specif	ck, White,			
Maryland 21215-0020	within 72 h one. then "netu he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grada complatad	(1-4or 5+)	16a. Deced (Giva life.	dent's Usua kind of wor DO NOT us	k done	during mos	t of work	ring	16b. Kind ol B				
5	Her to		17. Father's Name (First, Middla, L	-		Seam	stres	S	10 14-11-	ala Ataur	Shirt Mfg. Co. Name (First, Middla, Maiden Surname)					
and	d be in and of ceve	o Be	John	-	rson				E11				ne)			
a _Z	2 should and Man is marks numetic	10	19a. Informant's Name/Relationshi		10011	19b. Mallir	ng Address	(Stree	-	_	Johnson al Route Number, City or Town, State, Zip Code)					
Baltimore, Ma	Health wm 27 ther tr		Patricia Brown 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation		20b. Pla		7 Cros	nwe	ll Ave			MD 2	1804			
ij	ment of tank if he jury or o		4 □ Donation 5 □ Øffer (Spe	ecify)	Spr	inghi	11 Me	mory	Garder	ns d	4/28/97	Hebron	n,MD			
Bal	Depart Impor any In		21. Signature of Funeral Service U	censes //	1//				ass of Facilit Funer	•	lome					
		Н	23s. Part1 Enter the disease or o	omplications that	caused the death		501 Sr	NO	Hill	Rd.	Salisi	oury, MI	218	04		
	Physician		23a Part1 Enter the disease, or c shoot, or heart failure. List o		1								1	Interval Between Onset and Death		
K.	/Medical		Immediate Cause (Final diseasa or condition	Cer	Rerioso	lero	tie	Ca	2 Din	rae	cu an	Dese	Descent 4 yrs			
	Examiner	Ų.	resulting In death)		Due to (or	s a consec	wence of):	-	2					T		
	ted nsit	nine					the	croso	Ro	rose	•	14	4 yrs			
Ď,	execu in and iel-tra	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying		Due to (or	as a conseq	juence of):						į			
68760,	nte be nysicia he bur	edical	Cause (Disease or Injury that Initiated events rasulting In death) Last	C	Due to (or	as a conseq	uence ol):						-			
×	certificate be executed ding physician and use as the buriel-transit	2	rasulting in death) Last	d												
. 80	after lfor u	Physician/	Part II, Other aignificant condition	e contributing to	death but not resul	ting in the u	nderlying o	auce a	wen in Part I		23h Did	tohecco use co	otribute t	o the cause of death?		
<u>Р</u>	at the d by the stached	Phys	Park	r	7		- A	(· 1/ Δ		1 🗆			bably 4 Unknow		
	8 6 8	by	0		- 0	- 0	1				111111111111111111111111111111111111111	- / 20 2 - 2	T			
Hecords,	need houl	Completed	Essente	el s	Hype,	Rose	un	_			24a. Was	an autopsy med?	av	ere autopsy findings allable prior to empletion of cause		
	hes ye 2	dwc	Perman	100	-	D	1				10	Yes 20XNo		death?		
Vital		BeC	25. Was case referred to medical	y con	cery	Je	Lea	-K-R	26 Place	of Deet	h (Check only o		1	Yes 2K No		
of <	0 0	TOE	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1	Inpatient 2 E	R/Outpatien	t 3□ DO	A O	ther:			dence 6 Oth	ner (Specia	(y)		
Division o	Attending Ph ir death. ector: Atter thi by the funeral	Certification:	27. Mannar of Death 1 Netural 5 Pending investiga	tion	of Injury onth, Day Year)	28b. Time of Injury	M 2	Bc. Inju Wo	uryat ork?]Yes 2 □		28d. Describe	how Injury occur	rred			
	al or Attendes s efter deat il Director: od in by the	Sertifi	3 Sulcide 4 Homicide Could not be determined 28e. Plece of Injury - At home, larm, street, factory, office building, etc. (Specify)								28f. Location (City or To		ber or Run	al Route Number,		
	To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)	taminer: On the b	e best of my know besis of examination oner stated.	ledge, deeth on and/or inv	occurred a restigation,	it the t	ime, dete en opinion, dea	d plece, th occuri	end due to the red at the time,	ceuse(s) and ma date and place,	anner as s and due t	itated. the cause(s)		
	Velth To t	¥ L	29b. Signature and title of certifier	7/	Da.	2	_	_	se number			29d. Date signe				
		7	Hegeri	M. ! /5	selle	200		12	950	25		4-2	4-	97		
		A	Name and address of person with GREGORIO M.					IN	ABER	RY	DR., S	ALISBU	IRY	MD. 2/801		
	Sta Registr		31. Date filed (Month, Day, Year)	5 1997	Registrar's Signatu	char Ra	rde II						=/-1			
	3.5			0 1001	-1											



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** JAY **EDWARD** TALLENT 04 22 97 0745 /Medical 4a. Facility Name (If not Institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Undar 1 Yaar | If Under 24 Hrs. 5. Sociel Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (State or Foraign Country) **Funeral** 1 X M 2 □ F Months Deys Houra 222-22-7388 VIRGINIA 59 26 1937 WEST Usual Rasidanca of Dacedant 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits MD. WICOMICO SALISBURY 1 ☐ Yas X ☐ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 702 NAYLOR MILL ROAD, APT. # A 21801 U.S.A. 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Yeer or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxicen, Puerto Rican, etc.) 14. Rece - Amarican Indien, Bieck, White, etc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: WHITE à 3 ☐ Widowad 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 OWNER CONSTRUCTION CO. 17. Fethar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Surnama) Be WALTER E. TALLENT 2 MYRTLE B. SANFORD 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) GREGORY E. TALLENT-SON 28061 ADKINS ROAD, SALISBURY, MARYLAND 21801 20a. Mathod of Disposition 20b. Place of Disposition (Name of cametary, cremetory or other place) Dete 20c. Location - City or Town, Stata

Physician Examiner

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If flem 27 is marked other th any injury or other traumatic event, tra any injury or other traumatic event, tra

Director

r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiena.

Baltimore, Maryland 21215-0020

law requires that the death certificate be axecuted burial-transit attending physician for use as the burie the Ses signed by the a peen certificata has Hospital or Attending Physician:
24 hours aftar death.
 Funeral Director: After this certified.

Division of Vital Records, P.O. Box 68760.

Physician/Medical Examiner þ Completed Be 2 completely filled in by tha funeral Certification:

	4 Donation 5 Other (Specif	JRemovel from Stata	SPRINGHILL	MEM. GARDENS	4/25/97 HEBRON,	MD.
	21. Signature of Funeral Sarvice Licer	Soun	(/	and Address of Fecility FUNERAL HOM	E,705 E. MAIN S	21804 I.,SALISBURY,MI
	Part1. Entar tha disaasa, or com shock, or haart failura. List only	plications that caused the de- ona causa on each lina.	ath. Do not enter the mo	da of dying, such es cerdi	ac or raspiratory arrast,	Approximata Intarval Between Onset and Death
	Immediata Causa (Final disaasa or condition rasulting in daath)	a. ARTERIO	SCLEROTIC (ARDIOVASCUL!	AR DISEASE	
uer	,	Due to	(or as a consequanca of):		
Examiner	Sequentially list conditions, if any, laading to Immadiata cause. Enter Underlying	b. Dua to	(or as a consequanca of):		
edical	cause. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in deeth) Last	c. Due to	(or as a consequence of)	:		
Completed by Physician/Medical	Part II. Other significant conditions of DIABETES MELLITUS		esulting In the underlying	ceusa givan In Part I.		ntribute to the cause of death?
piered by	DIADELES MEGILIOS	, NID			24a. Was an autopsy performed?	24b. Wara sutopsy findings avellable prior to completion of cause of death?
E					1 ☐ Yes 2 🎇 No	1 ☐ Yas 2 ☐ No
0	25. Was casa raferred to medical axaminar?	Hospital:		Other	aath (Check only ona)	
2	1 ☑ Yas 2 ☐ No 27. Manner of Death		XER/Outpatient 3□ D	OA 4 Nursing	Homa 5 ☐ Rasidenca 8 ☐ Oth	
Sation	1 Natural 5 ☐ Panding 2 ☐ Accident invastigation		28b. Tima of Injury M	28c. Injury at Work? 1 □ Yas 2 □ No	28d. Dascribe how Injury occur	rea
	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicida datarmined	28a. Place of Injury - At building, atc. (Space	homa, farm, street, facto sify)	ry, office	28f. Location (Streat and Numb City or Town, Stata)	per or Rural Routa Number,
edical Certification:	29a. Cartifier 1 ☐ Certifying Phyone) 2 ☐ Medical Example 1	ysician: To the best of my kn ninar: On the basis of examin and mannar stated.	owiedge, deeth occurred action end/or invastigation	at the time, date end place, in my opinion, death occ	e, and dua to the causa(s) and ma urred at tha tima, data and piece,	annar es statad. and dua to tha ceusa(s)
D I						

29c. Licansa number

D03599

29d. Deta signed (Month, Day, Year)

04-22-97

DHMH 16 Rev 6/95

State Registrar

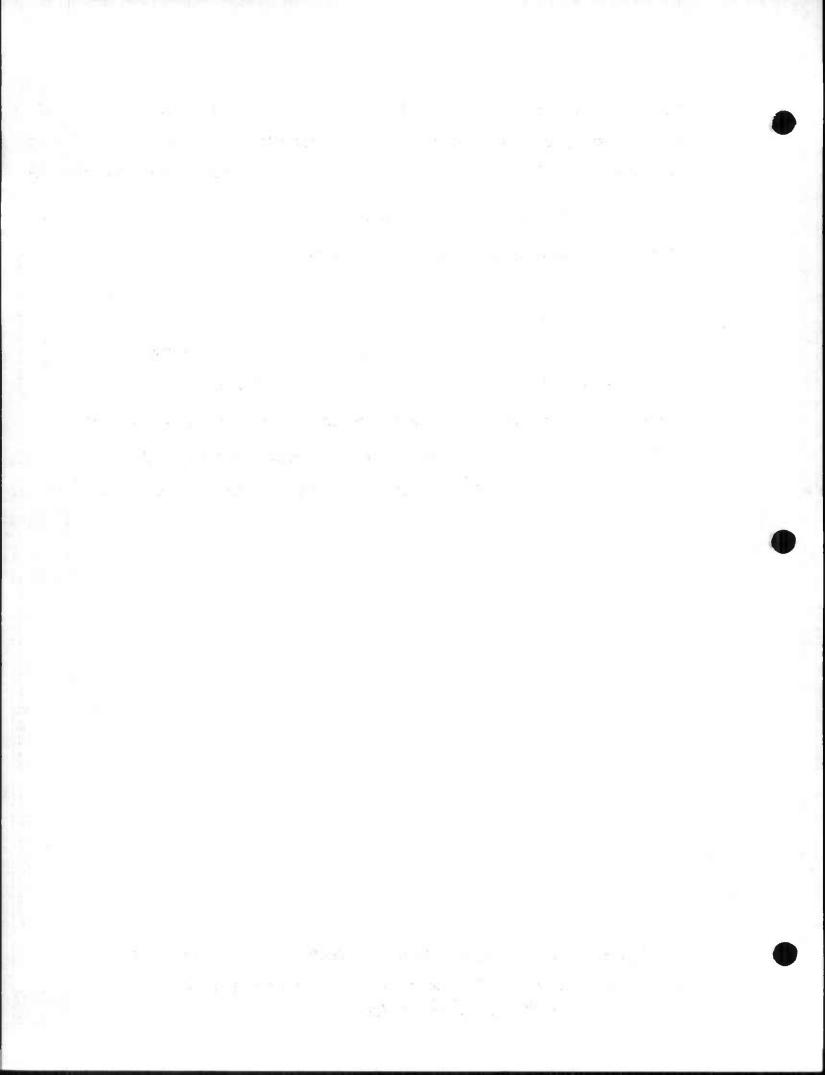
To the Vithin 2

29b. Signatura end title of certifiar

D. M. E.

30. Name and address of person who complated causa of death (item 23a) (Type, Print)

JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801 32. Registrar's pignature



Please Type or Print In Biack indeible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Deta of Death 3. Time of Death MAY **Physician** JOHN W. TRIGGER , SR. 4 :00 AM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 19310 Clubhouse Road Gaithersburg Montgomery 5. Social Security Number If Undar 1 Yaar If Under 24 Hrs.

Months Deys Hours Min. 8. Data of Birth Month, Day, Year) May 23, 1918 9. Birthplece (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 579-03-2538 Yrs 78 Director Usuel Residence of Decadent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. fnside Clty Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Menylan Department of Heelih and Mentel Hyglene. Important: If term 27 is marked other than "natural;, or itsms 23a or 28a-4 show any injury or other traumatic svant, if its Mexical Examiner must be notified as 1 ☐ Yes 2√ No Directo Maryland Gaithersburg Montgomery 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 8413 Hawkins Creamery Road 20882 United States Funeral 12. Was Dacedant Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, atc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☑ Yas 2 ☐ No If Ŷes, Give Yaar or Datas: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White þ 3 ₩ Widowed 4 Divorced WW II Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Bricklayer 5 0 Masonry 17. Father's Nema (First, Middle, Last) 18. Mothar's Neme (First, Middle, Melden Sumeme) John T. Trigger Lillie Bell Stevens 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John W. Trigger, Jr./ Son 2411 Doubs Court, Adamstown, Maryland 21710 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Steta Dete 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Parklawn Cemetery 5/9/97 Rockville, Maryland 21. Signeture of Funaral Service Licensas 22. Neme end Addrass of Facility Muriel H. Barber Funeral Home P.O. Box 5038 Laytonsville, Maryland 20882

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not antar the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical June of Examiner Examiner ettending physician and for use es the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Box 68760. Physician/Medical thet initieted events resulting in deeth) Last Due to (or as a consequence of) Pert If. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Sema þ 24b. Were autopsy lindings aveilable prior to complation of cause of death? Completed 24a. Was an autopsy certificate hes No No 1 🖂 Yas 1 ☐ Yas 2 ☐ No Division of Vital 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Inpatient 1 Yes 2 -No Other: 4 Nursing Home 2 5 Residence 8 Other (Specify) 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: To the Hospital or Attanding P within 24 hours after death.

To the Funeral Director: After t completely filled in by the funeral complete Neturel 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28l. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifie 1 Cartifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner steted. (Check only 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) Mund Mac 30. Nente and address of person who completed cause of deeth (Item 23e) (Type, Print) Robert Millman, M.D. 9707 Medical Center Drive, Rockville, Maryland 31. Dete filed (Month, Dey, Year)

State Registrar

WAY 1 2 1007

32. Registrer's Signeture

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Funeral

Director

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Department of H Important: If Its any Injury or ot once.

Physician /Medical

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Peges 1 and 2 should be filed within 72 hours efter

3altimore, Maryland 21215-0020

the Medical Examiner must be notified at

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene CSMificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Month **Physician** APRIL lea que Kobert ee. /Medical 4a. Facility Nama (If not institution, giva streat and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fallston General Hospital Fallston Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Yaer) 1 M 2 □ F Yrs. 218-28-1066 70 Jan. 24, 1927 Maryland Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Directo Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 51 East Jarrettsville Road 21050 USA Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Spacify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. 1X Yas 2 No
If Yas, Giva
Yaar or Datas:1948-52 1 ☐ Navar Marriad 2 Marriad 1 ☐ Yas 21 No Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Machine Operator Tool Manufacturing 12 17. Father's Nema (First, Middla, Last) 18. Mothar's Neme (First, Middla, Maiden Sumama) Be Laura Bell Nicholson Van Gilmore Teaque 2 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 21050 19a. Informant's Name/Raiationship (Type, Print) May Teague, Wife 20a. Method of Disposition 51 East Jarrettsville Road, Forest Hill, Maryland 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 Donation 5 Wother (Specify) enteringent Bel Air Memorial Gardens 4/29/97 Bel Air, Maryland 22. Name and Address of Facility Howard K. McComas III Funeral Home, P.A. 50 West Broadway Street, Bel e/or complications that coused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, List only one cause on each line. 50 West Broadway Street, Bel Air, Maryland 21014 23a. Part V Enter tha diseete shock, or haart feilura. Approximata Intarval Between Onsat and Death Immediate Cause (Finel PNEUMONIA BILATERAL disaasa or condition rasulting in death) Dua to (or as a consequence of): METASTATIC CARCINOMA OF BLADDER 6 MONTHS Examine Sequantially list conditions, if any, leeding to immadiata causa. Entar Undarlying Causa (Disaasa or Injury Dua to (or as a consequence of) Physician/Medical thet initieted avents Due to (or as a consequence of): rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 PTYss 2 □ No 3 □ Probably 4 □ Unknown þ 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to Completed complation of ceusa of death? 1 Yas 2 1 No 1 ☐ Yas 2 ☐ No Be 25. Was cesa rafarred to medicei axaminar? 26. Piaca of Daath (Check only ona) Hospital: P 1 Yas 2 No 1 ☐Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner or Attending Physician: The lew requires that the death certificate be executed physician and the burial-transit Box 68760 USB Division of Vital Records, P.O. signed t page 2 s certificate director, this uneral n 24 hours after death.

• Funeral Director: Aft bletely filled in by the fur

Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 27. Manner of Daath 1 Natural 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Pending 1 ☐ Yas 2 ☐ No Invastigation 2 Accident 6 Could not be datamined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 29a. Cartifiar Medical (Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the ceuse(s) end mennar steted.

29b. Signatura and titla of certifiar

29c. Licansa number

29d. Data signed (Month, Day, Year)

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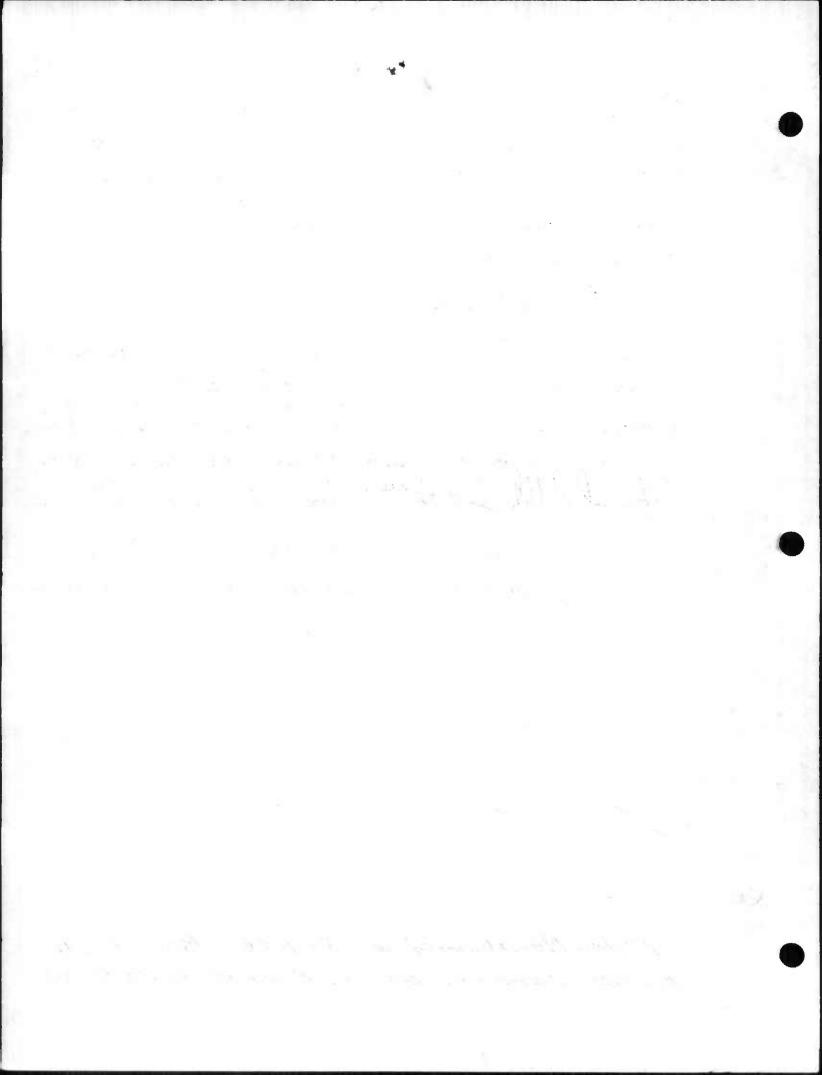
D09086 APRIL 28 1997

30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print) ANDAGN NOWAKOWSKI, MD 31. Date filed (Month PR)

125 N. WAIN ST. BERARMAZIONS

State Registrar 32 Hodsmar Asignatura Revisit

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State of Maryland / Department of Health and Mental Hygiene 97 | 4642

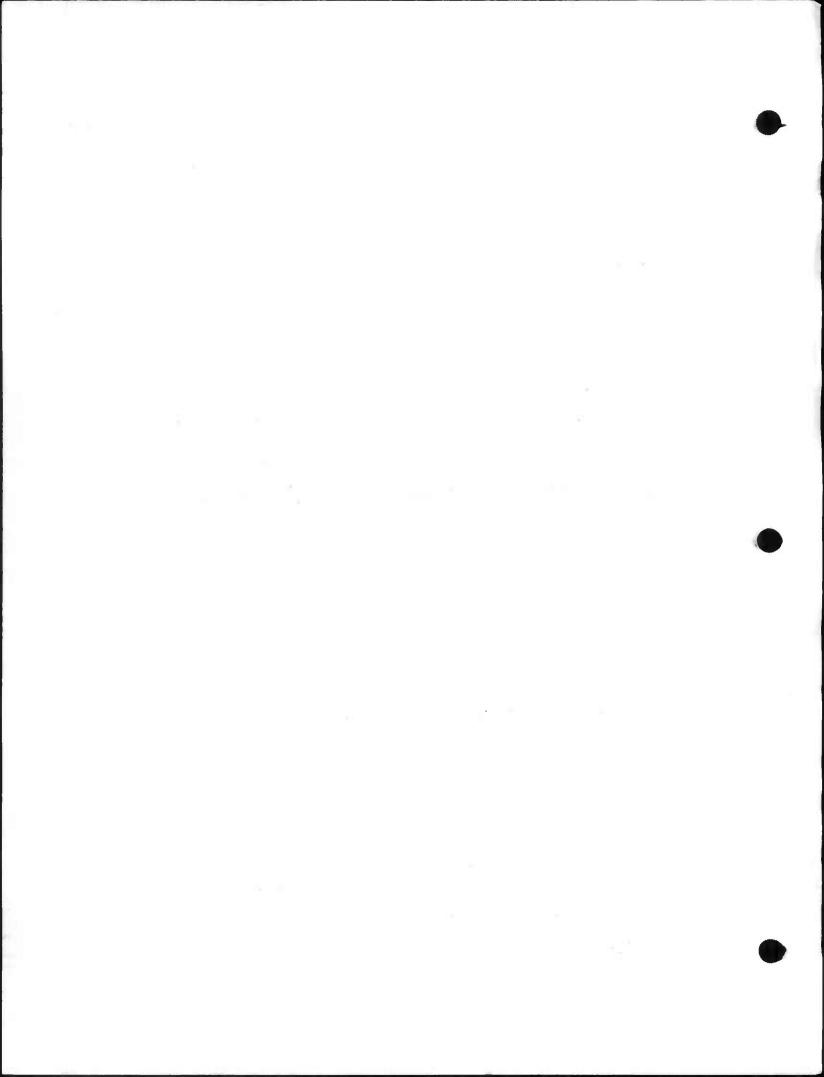
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100		1. Decedent's Neme (First, M	liddle, Last)							2. Dete of De			W	3. Time of Death
Physi		GEORGE M.	THEFY							Month APRIL	25	19	Yeer	6:25 PM
/Med Exam		4e. Facility Neme (If not institu		end number)				4b. City, To	wn, or Lo	ocation of Deal			of Death	0.23 IH
LABIT	IIIICI	501 MACDUDED	CTDPP					CIDAD	COT A	ATTO.				
		501 MAGRUDER 5. Sociel Security Number	6. Sex	7 Ag	e (In yrs. last	hirthday	If Under 1 Ye	CUMB er If Under		8. Dete of Bi	eth	ALL	EGANY	(Custo on Continu
Funera			1DXM			Yrs.	Months Dey		Min.	(Month, D	ay, Year)		9. Birthpi Coun	lece (Stete or Foreign try)
Directo	r	309-05-2584			84					NOV 26	, 19	12	INDI	ANA
pg *		Usuel Residence of Decedent 10e. Stete 10b. Cou			10c. City, To	wn or Loc	eation						Tar	Dd. Inside City Limits
show	<u> </u>		,		Too. Ony, To	, , , , , , , , , , , , , , , , , , ,	ation)						- 1	
Mo Hall	5	MARYLAND ALLE	GANY		CUM	BERLA	AND							1 Yes 2 No
21215-0020 d within 72 hours after death with the Menyland plane. r then "neturel", or Items 23s or 28s-f show the Medical Examiner must be notified at	Director	10e. Street end Number					10f. Zip Code	•			10g. Cit	izen of	What Coun	try?
h wi		501 MAGRUDER	CTOFFT				2150	2			USA			
deat deat	Funeral	11. Meritei Stetus	12. W	es Decedent	Ever in U,S.	13. W	les Decedent o	f Hispenic On	igln? (Sp	ecify Yes or No		14. Réc	e - Americ	an Indien,
The state of	Ē	1 Never Merried 2 N	and the second second	med Forces? ☐ Yes 201		If	Yes, specify C	uben, Mexicar	n, Puerto	Rican, etc.)		Bla	ck, White,	etc.
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yaic is ce	10	1 Ves 2 No	7 Hospita	al: 1 🔲 Inpatie	ent 2 ER/	Outpatient	3□ DOA	Other: 4 Nu	ursing Ho	me 5 Res	idenca	6 □Oth	ar (Specify	r)
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DIVISION or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Cou	uid not be	Place of inju	unu - At home	form etro	et, fectory, offic			28f Location	(Street or	nd Numb	ner or Rura	l Route Number,
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THE		30. Nema end address of pers	on who complat	ed causa of d	aath (Item 23a	Type, P	rint)	12	6.	in Res	rlas	ud	. 0	ld.
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

TH DAY	3. TIME OF DEATH									
9, 1997	8:30 p M									
H.	8. BIRTHPLACE (State or Foreign Country)									
, 1918	WEST VIRGINIA									
9c. COUN	TY OF DEATH									
AL	LEGANY									
	10d. INSIDE CITY									
	LIMITS?									
10a CITIZ	EN OF WHAT COUNTRY?									
US										
v Yes or No.	14. RACE — American Indian,									
۱.)	Black, White, alc. Specify:									
	WHITE									
F BUSINESS/INDU	STRY									
TE MANII	EACTIDING.									
	FACTURING									
JANE KERNS I Route Number, City or Town, State, Zip Code)										
OAKS DRIVE, MONROVIA, MD 21770										
c. LOCATION — C	lly or Town. State									
4 Donallon 5 Other (Specify) HYNDMAN, PA 15545										
HYNDMAN CEMETERY MAY 2, 1997 HYNDMAN, PA 15545 H. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ACCRESS OF FACILITY HARVEY H. ZEIGLER FUNERAL HOME										
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	Onset and Death									
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Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. CERBRD VASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
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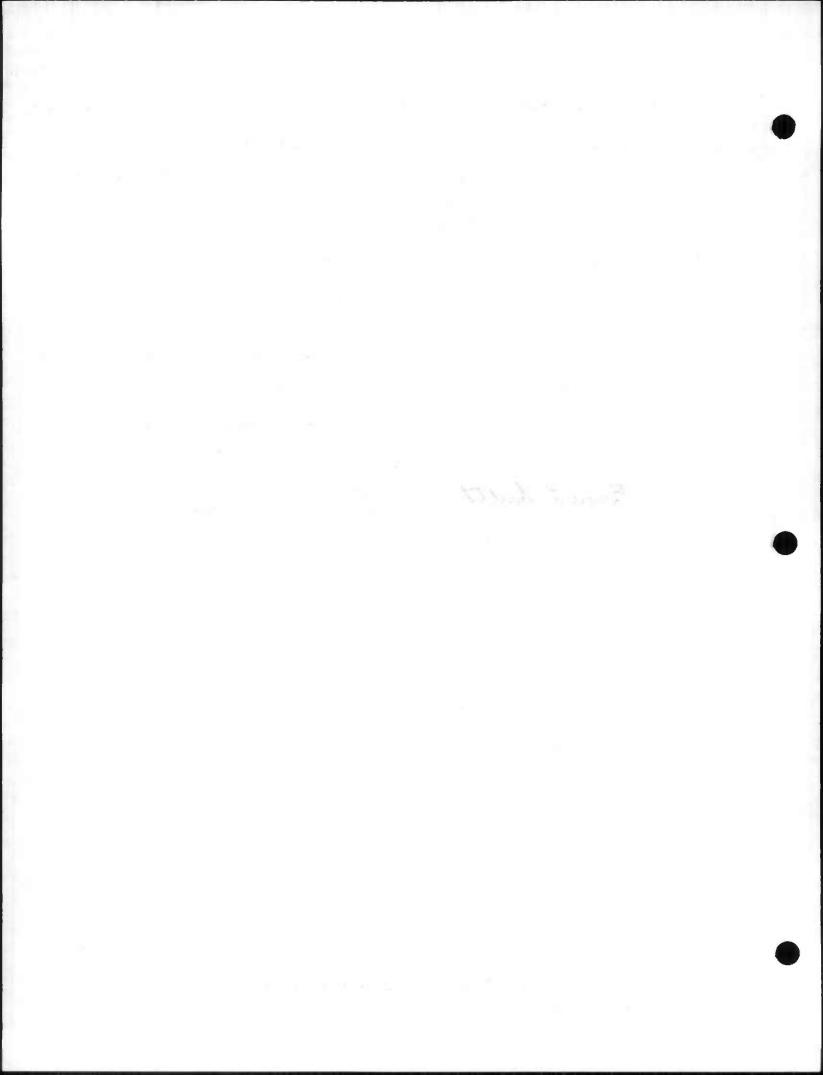
State of Maryland / Department of Health and

Mental Hygiene	97	L	6	Ų	L
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State Registrar

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Examir Funeral Director	niner	4e. Facility Name (If not institution, give street end number)					4b. City, Town, or Location of Deeth 4c. County of Death					
	-	Sacred Heart Hospital 5. Social Security Number 6. Sex 7. Aq		Age (In vrs. last i	e (In yrs. last birthdey) 50 Yrs. If Under 1 Yea Months Days		Cumberla If Under 24 Hrs.	and 8. Dete of Birth	(, Year) Country)			(State or Earnier
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Many -fet	Þ	WV Mineral Keyser					1 ☐ Yes XXVo					
r 28e	Director	10e. Street end Number			10f. Zip Code			1	10g. Citizen of Whet Country?			
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l within 72 hou liene. r than *nature	Completed	15. Decedent's Education (Specify only highest grede completed)			16a. Decedent's Usual Occupation (Give kind of work done during mos)			king	16b. Kind of Business/Industry			
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Tage of		21. Signature of Funerel Servica Licansee 22. Neme end Address of Facility										
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	Physic /Medi		META IONE	TILLINGHAS	T			MAY		1997	3:00 P
	Exami		4a. Facility Nama (If not institution, giva s	treet and number)			4b. City, Town, or Lo	ocation of Death	4c. County	of Death	
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	Funeral		5. Social Sacurity Number 6. Sex		Months	r 1 Yaar Days	Hours Min.	(Month, Day	Year)	9. Birthplace	Stata or Foraign
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2-0	72 hours	Completed	15. Decedent's Educ	ation	16a. Decedent's Usu	al Occup	pation		16b. Kind of Bu	sinass/Indust	ry
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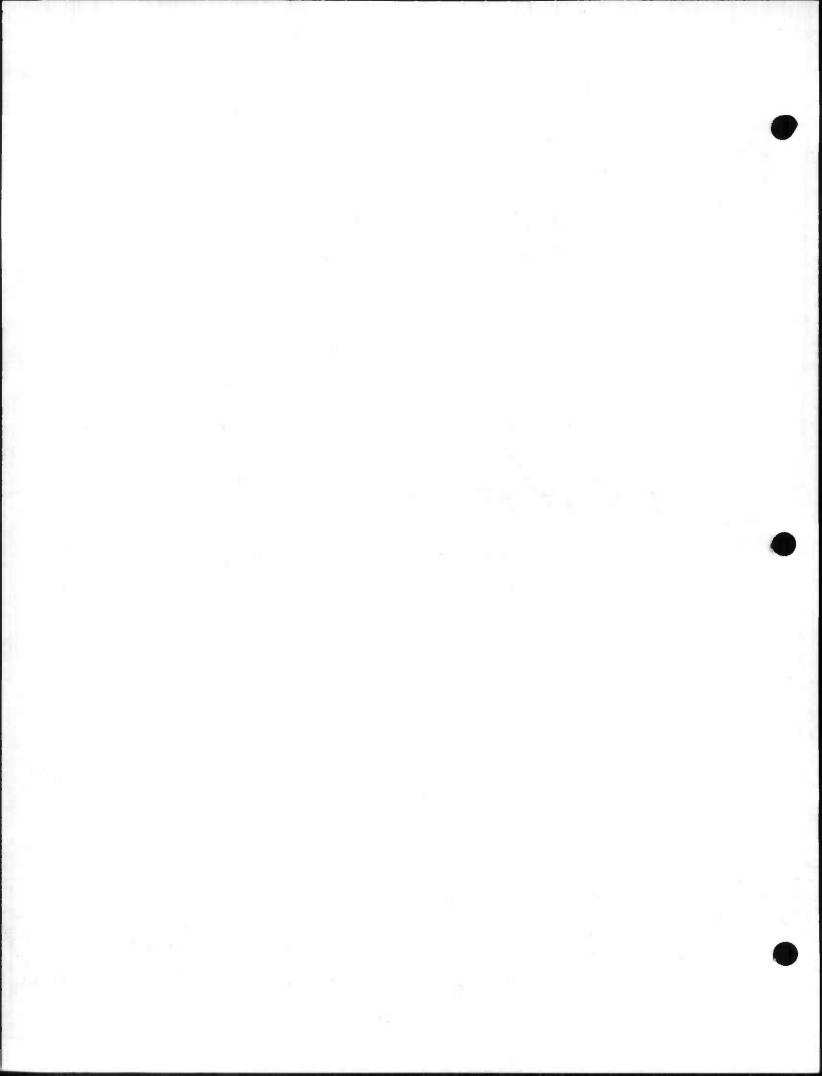
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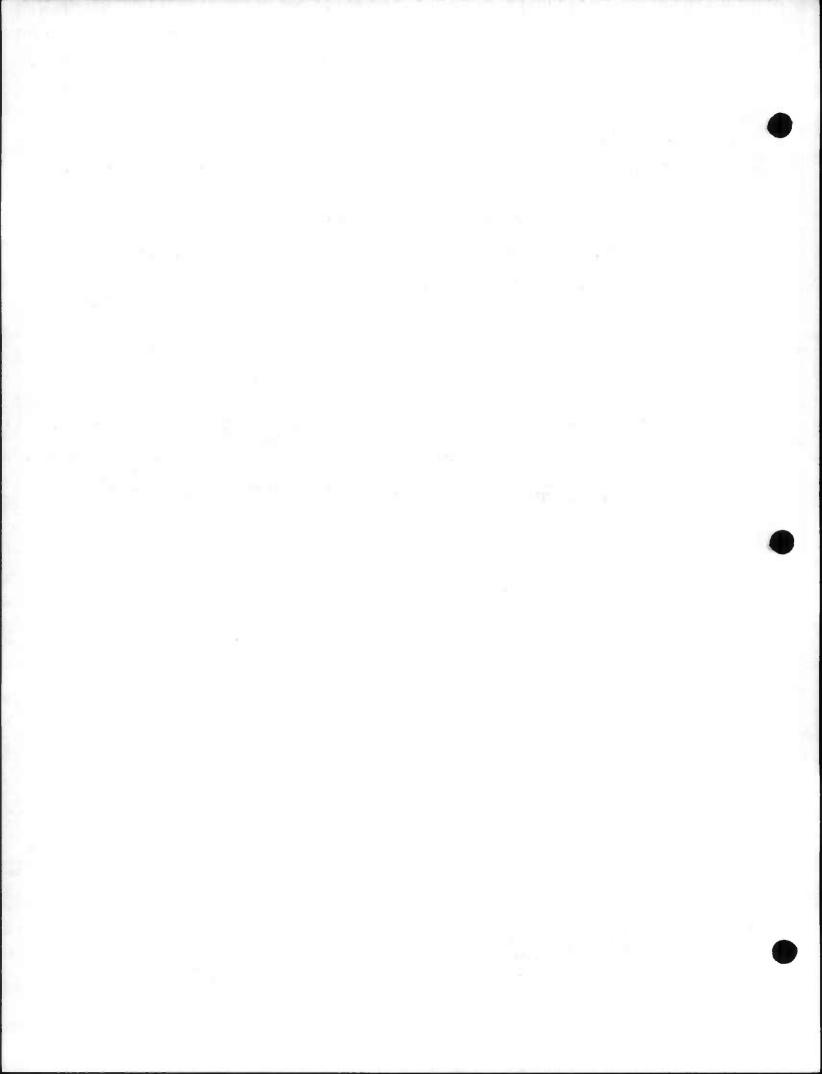
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	/Medi		Phyllis Irene	Thompson				April		97	0330			
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	Funeral Director		5. Social Security Number 218-34-3532 Usuel Residence of Decedent	Sex 1	s. lest bi	irthday) If Under 1 Year Yrs. Months Days			th y, Year) 1935	9. Birthple Country Marti	ce (Stete or Foreign y) Land			
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לי היי	5 2	tec	15. Decedent's (Specify only highest of	Education	16a	Decedent's Usuel Occu (Give kind of work done	petion	ndkina	16b. Kind of Bus	iness/indu	istry			
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arylan	Went	10	Charles H. Shant	Z			Eth	el L. Gr	ove					
and and	pue man	-	19a. Informent's Name/Reletionship	(Type, Print)	198	b. Meiling Address (Stree	end Number or F	Rural Route Number	er, City or Town, S	state, Zip C	code)			
C	t of Health and Men If Item 27 is marks or other traumatic		Emmett K. Thomps	on (Husband)	1	11 W. Baltim	ore St.	Apt. 114	Hagersto	wn Mc	1. 21740			
0 - S	Department of Her Important: If Item any Injury or othe pace.		20e. Method of Disposition	20b.	Piece C	of Disposition (Neme of ary, cremetory or other ple	ool .	Dete	20c. Location - C	ity or Tow	n, State			
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death cert	ettendi for use	ian								1				
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or Attending Physician: T	After fune	ion	1 ☐Naturel 5 ☐ Pending	(Month, Day Year)		Injury Wo	rk?` IYes 2⊡No	200. Describe	now injury occurre					
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State of Maryland / Department of Health and Mental Hygiene 97 | 4647

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	Funeral Director			Sex XXM 2□ F	7. Age (In 53	yrs. last birti		If Under Months	Deys	If Under:	Min.	8. Date of Bir (Month, Da Dec. 7	of Birth h, Day, Year) 7, 1943		9. Birthp	ntrv)	e or Foreign
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	how	_	10a. Stete 10b. County			c. City, Town	or Loca	ation							1		City Limits
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	r Hen	Funeral	1 Never Married 2 Married	Armed Fo	rces?	1967	lf Y	Yes, spec	cify Cub	an, Mexican	, Puerto	Rican, etc.)			ck, White,		
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Maryland	d be sental	o Be	B.D. White	•/								ia Star		Samo	10)		
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Ball	permit. Page Department of Important: If any Injury or once.		4 Donetion 5 Other (Specify) Maryland Veterans Cemetery Cheltenha 21. Signeture of Funeral Servica Licensee 22. Name and Address of Facility Lee Funeral Home, Inc													ld	
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	thin 2 the I	Med	one) 29b. Signeture and title of cartifier	and referre	er steted.					e number				1 1		Day, Year,	
	2 × 1 × 8		A A A	TII										IL 2		997	
•			30. Name and address of person who	completed	e of death	(Item 22a) /	Type D-		50 1		PDTI	AEMED D		TT 2	. J L'	771	
			ROBERT A. GASSER	. Caus	ज जनवा	(110111 ZOR) (1	ype, ri			WEST P			ע				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death Day 1997 April **Physician** 26, 35 A Whittington Mabel /Medical 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva streat and number) 4c. County of Death Examiner Crisfield Somerset Edw. W. McCready Memorial Hospital If Undar 1 Yaar 9. Birthplaca (Stata or Foreign Country) A A If Undar 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) **Funeral** 214-42-8245 Days 1□M 20 F Yrs Director Usual Rasidance of Decedant 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or flems 23s or 28s-f ehow 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f sho traumstic event, the Madical Examinar must be notified at rist MD 1 Nas 2 No Directo Omerson 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? 1817 oadway Funeral Was Decedant Evar In U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) Race - Amarican Indian Biack, Whita, atc. 1 Nevar Married 2 ☐ Married 1 ☐ Yas 2 No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🗷 No Specify: Completed by Specify: 3 Widowed 4 Divorced 18a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DQ NOT usp ratired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) ha borer catogo 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Melden Surnama) Be Whitting HARRict P con ciling 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) permit. Pages 1 end 2 st Department of Health and Important: If Item 27 is n any Injury or other traun once. Ashel Blanken Ship JT Hickardia 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 5-3-97 Unrion 4 Donation 5 Other (Spacify) Pcer Comotery 21. Signatura of Finaral Sarvice Licensas Nama and Addrass of Fac Arthony E. Ward Funeral 314 Cove ST. Crisfield, V Do not antar tha mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Entar tha disaasa, dreemplications that caused the deaps shock, or heart failura. List only one cause on each line. Approximete Intervel Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) UREMIA MONTHS Examiner Dua to (or as a consequenca of) Examiner HYDRONEPHROSIS buriel-transit Attending Physician: The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury and CERVICAL CANCER Box 68760. METASTATIC attending physician Physician/Medicai the that initiated evants rasulting in daath) Last Dua to (or as a consequance of): esn signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ANEMIA. SEVERE þ 24a. Was an autopsy performed? 24b. Wara autopsy findings evalleble prior to complation of ceusa of death? Completed hes 2 No certificate 1 ☐ Yas 2 ☐ No funeral director, 25. Wes casa rafarred to medical axaminar? Be 26. Placa of Daeth (Check only ona) Hospital: 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Menney of Death 28d. Dascriba how injury occurred 28b. Time of 28c. Injury at Work? After 1 (3 Natural 5 Panding death. 1 ☐ Yas 2 ☐ No invastigation 2 Accident To the Hospital or Attent within 24 hours after deat To the Funeral Director. 6 Could not be datarminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) filled in by 4 Homicida ledical 29a. Cartifian 1 Certifying Physician: To tha bast of my knowladge, death occurred et the time, dete and place, and dua to tha causa(s) and mannar as steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated. 2 29b. Signature and titla of certifier 29d. Data signed (Month, Day, Year) ware MYSICIAN 30. Nama and address of person who complated cause of deeth (Item 23e) (Type, Print) Dr. T. Kanchana, Main Street, Crisfield, Md. 21817 Julia disputer hardell

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

APR3 0 **19**97

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month e L AMOUS WEBR 5.50 PM 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death Waterview Health Care Center Wicomico Salisbury If Under 24 Hrs. Hours Min. July 24 1908 Birthplace (State or F Country) Maryland If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2XF Yrs. 88 206-20-8830 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Wicomico Maryland Quantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Box 6145 21856 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Black. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic None 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) **Emory Pinkett** Famie Way 19e. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1036 E.Mount Pleasant Ave. Phila. PA 19150 Flora Derrick (NIECE) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★Burlal 2 □ Cremation 3 □ Removal from State 1/26 4 ☐ Donation 5 ☐ Other (Specify) Quantico, Md. Quantico Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 821 West Rd.Salisbury,Md.21801 Glady Stewas AB1 23a. Part1. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Dementiq Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Tyanic Bro Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Higgs Failure. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yes 20 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if frem 27 is marked other than "natural", or frems 23s and other traumatic event.

pue attending physician Physician/Medical s been signed by the should be detach. Completed After this certificate Be 2 Certification: after death filled in by the

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Medical

or Attanding Physician: The law requires that the death certificate be executed

death.

To the Hospital c within 24 hours at To the Funeral D completely filled

Division of Vital Records, P.O. Box 68760.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical 1 ☐ Yes 2 No 27. Menner of Death

28a. Dete of Injury (Month, Day Year) 5 Pending Investigation

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

3 Suicide 4 Homicide

1 Natural

2 Accident

NIA. 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and menner as steled.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and menner as steled.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Data signed (Month, Day, Year)

Thomas V. Tisery. MD

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

RIVERSIDE DRIVE. SALISRURY. Ř24.1997

State Registrar

32. Degistraria Signature
Selva Whurther Randell

y 8

State of Maryland / Department of Health and Mental Hygiene

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						Cer	TITICATE	ot Deati	n		Reg. No.			000	
			1. Decedent's Name (First, Middle	a, Last)						2. Data of D		V	3. Tim	e of Death	
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	/Medi Examii		4a. Facility Nama (If not institutio	n, give street and no	umber)			4b. City, 1	Town, or L	ocation of Dea	th 4c. Coun	ty of Death			
	LAGIIII	ici	Wicomico	Nursina	Home			Sa	lisb	urv		i com			
ŀ	F		5. Sociel Security Number	6. Sex	7. Age (In yrs.	lest birthdev)	If Under 1 Y		ar 24 Hrs.					te or Foreig	
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	and and		10a. Stata 10b. County		10c. City	y, Town or Lo	cation						10d. Insid	a City Limits	
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	19 the 1	Sc.	10e. Street and Number				-				100 011	140	-1-0		
	S & S	吉					10f. Zip Co	804			10g. Citizen of	SA	ntry?		
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Maryland	2 should and Men is marke sumatic	-	19a. Informant'a Name/Ralations	hlp (Type, Print)		19b. Mailin	g Addrass (S	treet and Num	ber or Ru	ral Route Numi	ber, City or Town	n. Stata. Zi	io Code)		
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>	Pr de la	#	4 ☐ Homicida datarm	Ined 406. Flace	e of Injury - At ho ling, atc. <i>(Specif</i>)	ипе, тагт, stre /)	et, factory, of	піса		City or To	8f. Location (Street and Number or Rural Routa Number, City or Town, State)				

1 Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the causa(a) and manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or invastigation, in my opinion, death occurred et the time, dete and place, and due to the cause(a) and menner stated.

Registrar

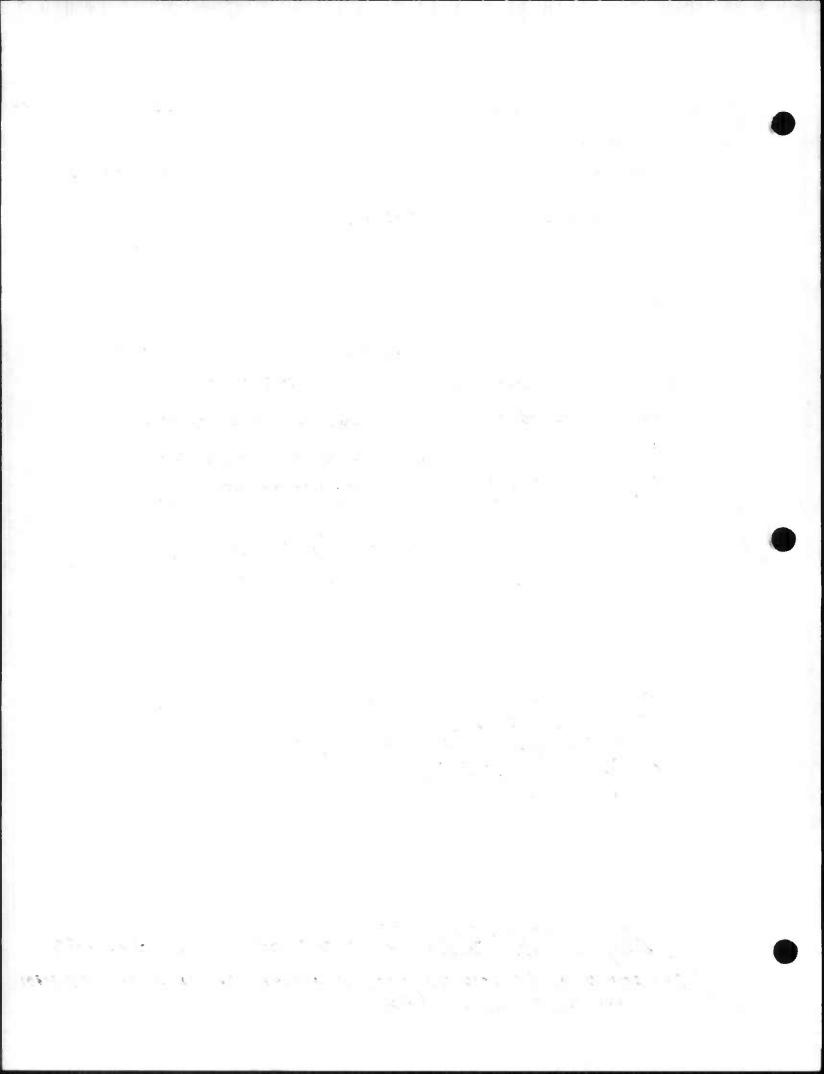
Wedical

29a. Certifier (Check only one)

GREGORIO State

BELLOSO MD: 530Z CHINABERRY DR., SALISBURY, MD 21801

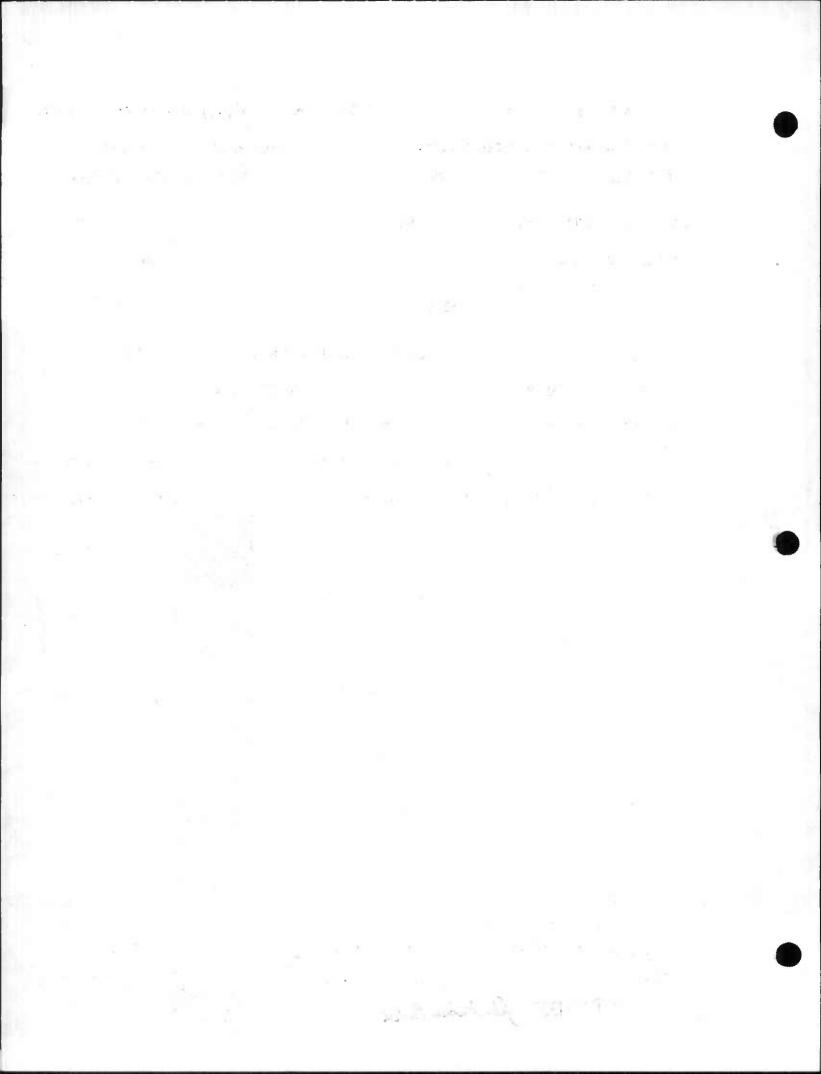
29d. Date signed (Month, Day, Year)



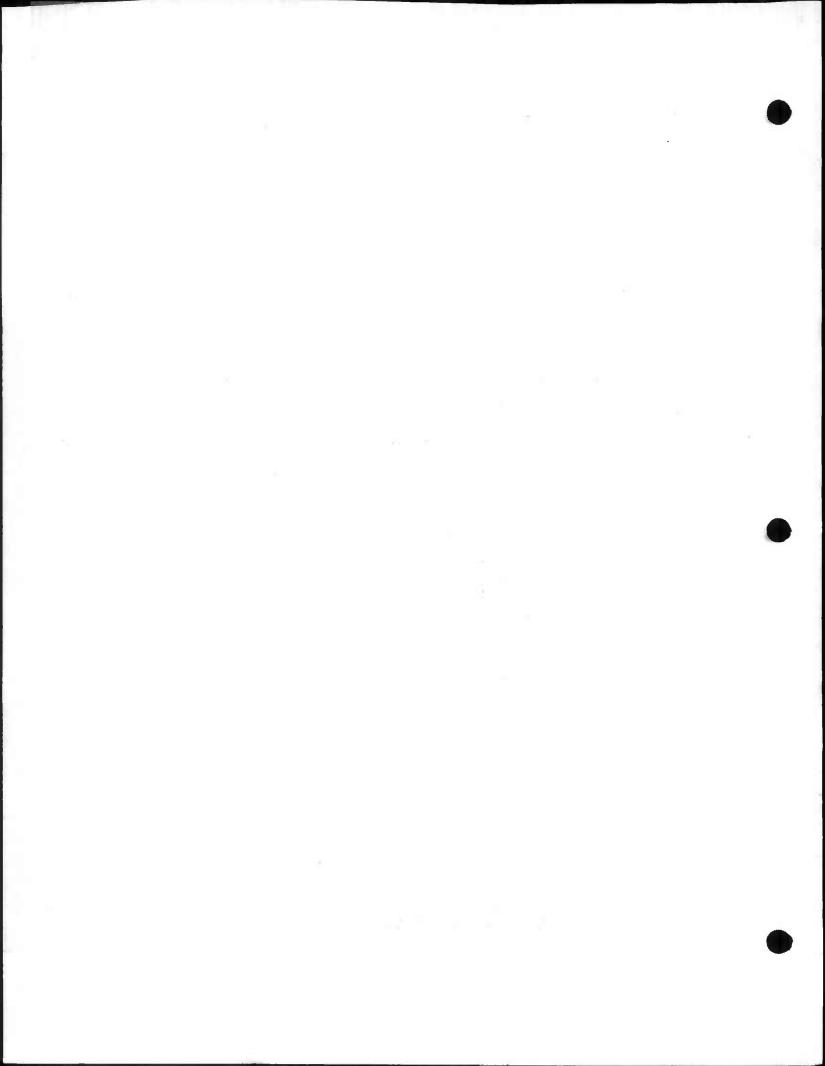
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	hysici /Medic		Decedent's Nemo LAW	e (First, Middle,	Last)			Wa	ren	M	ete of Death onth	Dey 22,19	Yeer	3. Time of Deeth
	xamir		4a. Fecility Neme (II	f not institution,	give street end nu	ım <i>bər)</i>			4b. City, T	own, or Location	of Deeth	4c. County	-	40
	neral		5. Social Security N 220-28-14 Usuel Residence of	umber 24	ONAL MED 6. Sex 1⊠ M 2□ F	7. Age (In yr.	ENTER s. lest birthda 64 Yrs.	y) If Under 1 Y Months D	ear If Unde ays Hours	SALISBU or 24 Hrs. 8. Do Min. 64 SEI	onth, Dey, Y			CO Nace (State or Foreign Natry) YLAND
land	M H		10e. Stete	10b. County		10c. 0	City, Town or	Location					1	0d. Inside City Limits
ле Мал	peutzo	Director	MARYLAND		ESTER		SHOWE	LL						1X Yes 2□No
with	5		10e. Street end Nun	nber				10f. Zip Co	de		10g	. Citizen of \	Whet Cour	itry?
eath	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	erai	10023 PI 11. Maritel Status	TTS ROA		edent Ever in	110 12		1862	rising (Caralty V	an an No	USA	a Amaria	an Indian
.0020 · hours effer death with the Maryland	ar, or nems 234 of 284-1 show	by Funerai	1 Never Marrie	_	Armed Fo	orces? 2 □ No ive		If Yes, specify		origin? (Specify Y an, Puerto Rican y:	etc.)		ck, White,	etc.
90		D D	3 Widowed			Detes: 1953		- double 11 - 10					WIII	
I s	Medical	Completed			grade completed)		(Giv	edent's Usual O re kind of work d DO NOT use n	ccupation one during mo etired)	st of working	16	b. Kind of B	usiness/Inc	Justry
d 2121 liled within Hygiene.	E 25	E	Elementery/Secon	ndary (0-12)	College (1-4or 5+)		TENANCE				POULT	RY	
	event,	Be C	17. Fether's Neme (First, Middle, L	est)				18. Moth	ner's Neme (First	, Middle, Me	iden Sumerr	10)	
ylan		ToE	LAWRENC	E W	ARREN				ED	DITH D	AVIS			
lar 2 shc end	traumatic		19e. Informent's Na	me/Reletionshl	p (Type, Print)		19b. Ma	iling Address (Si	reet end Numi	ber or Rurel Rou	te Num <i>ber, C</i>	City or Town,	State, Zip	Code)
	4 b		DOROTHY		EN/WIFE					ELL, MAR	YLAND	21862		
E0 6	or of		20e. Method of Disp		Removel from		Plece of Disp cemetery, cr	position (Neme of emetory or other	of rplece)	Det	e 20	c. Location -	City or To	wn, Stete
time Pa	injury		4 Donetion	5 Other (Spe	ecify)		ERGREI	EN CEMET	ERY	4/26	/97 BE	ERLIN,	MARY	LAND
Baltimo	eny in		21. Signeture of Fur	neral Service Li	(a) A	X)	22. Name end A			CFI RV	VVIIIE	DEI	AWARE 1997
			23a. Pert1. Enter the shock, or heer	e diseese, or o	omplications that	ceused the the							, DEL	Approximate
Physi /Med Exam	dical		Immediate Cause (F	inel		4 pox								Interval Between Onset end Deeth
		Jer	resulting In deeth)			Due to	(or es e cons	equence of):	1.1-50	Since	1			4 days
Bouted	the burial-transit	Examiner	Sequentielly list con	ditions,	■ b		or es e conse	equence of):	בנשאן צוי	-jnc	mme		1	(day)
760,	burial	ai E	Sequentielly list con if eny, leading to im- ceuse. Enter Under Ceuse (Disease or li that initiated events	lying njury	c. / /	nemor							1 -	sdays
ox 68760, 1 certificate be execut	r use es the	n/Medicai	resulting in deeth) L.	est	d.	Due to (or es e conse	equence of):						
	foru	cian												
P.O.	ched	Physicia	Pert II. Other eignific					underlying ceus	given In Pert	i. 2	3b. Did tobe	11	1000000	the cause of death?
That	e deta	by Pt	Can	cer o	of the	e Lu	19				1 🗆 Yes	2 No	3 Prot	pably 4 Unknown
I Records, P.O. Bo The law requires that the death are has been signed by the effect	should be detached for	Completed b								2	te. Wes en e performe		cor	ere autopsy findings elleble prior to expletion of ceuse
Be lay	99 2	E										. H.		deeth?
Vital I	or, pa		25. Wes cese referre	ad to medical					00 Di-		1□ Yes	2 No	1L	Yes 20 No
S con	direct	To Be	exeminer?		Hospitel:	Inpatient 2] ER/Outpatie	ent 3 DOA	Other	e of Deeth (Che lursing Home 5		о ПОФ	or /Canaih	e)
Vision of Vita Attending Physician: or death.	eral		27. Menner of Deeth		28a. Dete	of Injury	28b. Time		injury at Work?		escribe how			,
ath.	e fur	atio	1 Neturel 2 Accident	5 Pending Investigat		th, Dey Year)	Injury		work? 1 □ Yes 2 □] No				
Division of Vital for Attending Physician: T effect death.	d in by th	Certification:	3 ☐ Sulcide 4 ☐ Homicide	6 Could no determine	ad 286. Place	of Injury - At I ng, etc. (Spec	nome, farm, s	treet, fectory, off	ice	28f. L.c	cation (Streety or Town, S	et end Numb Stete)	er or Rure	l Route Number,
Division To the Hospital or Attending F within 24 hours efter death. To the Euneral Director: After	completely filled in by the funeral director, page	edicai C	29a. Certifier (Check only one)	Certifying Medical Ex	Phyeician: To the aminar: On the be	best of my kn ests of examin ner steted.	owledge, dea etion end/or l	th occurred et th nvestigetion, in r	e time, dete ei ny opinion, de	nd plece, end du eth occurred et ti	e to the ceus ne time, dete	se(s) and me end place, o	enner es st end due to	ated. the ceuse(s)
o the	dwo	_	29b. Signature end t	itle of certifier	1			29c. Lic	ense number		29d.	. Date signed	d (Month, i	Dey, Year)
- > -			▶ Wet	tene	Kulle		m	DA	41813			4/22	2/9	7
			30. Namerand address	JU	ian n	10 -	201	line	Bluff	Rd.	Sale	is her	y to	40 2180/
Re	Stat egistra	e ar	31. Dete filed (Mont	PR 251	997	poistrar's Sign	ature Lor Rad	II.	13			1		



	FOR 1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGII				
	1. OECEDENT'S NAME (First, Middle, Last)		,		DUMIN	2. DATE OF DEATH		3	. TIME OF OEATH	1
	Lawrence 1	Frowne	War	dron	Jr.	MONTH 2	4 9	7	8:25	PW
	4. SOCIAL SECURITY NUMBER 057-01-9897		n yrs. last birthday) 85 YRS.	IF UNDER 1 FEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year 11/19/11		Country)	LACE (State or Fore	oign
~	9a. FACILITY NAME (If not institution, give street Gull Creek Retire				OR LOCATION OF DE	EATH	9c. COUNT	Y OF OEA	ATH	
DIRECTOR	RESIDENCE OF DECEDENT	ment other		Berlin			Worc	este	r	
REC	10a. STATE 10b. COUNTY			TY, TOWN OR LOCAT	TION			1	IOd. INSIDE CITY	
	Delaware Susse	2X	MI	llsboro				1	XYES 2 N	10
FUNERAL	131 W. State Stre	et		101	1. ZIP CODE 19966		USA	N OF WH	IAT COUNTRY?	
5	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N U.S. ARMED			NC ORIGIN? (Specify n, Puerlo Rican, etc.)			- American Indiar White, etc.	n,
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYPES IF YES, GIVE WAR OR D. 1943-1945	ATES		2 NO Specify			Specify:		
8	15. DECEDENT'S EDUC	ATION	18a. DECEDENT'S	S USUAL OCCUPATION	ON	16b, KIND OF	BUSINESS/INDU	STRY	WILLE	
	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT a	work done during mo use retired.)	est of working					
COMPLET	12	7	attorne	ЭУ		corpo	ration	1awy	er	
	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Mai	den Surname)			
BE	Lawrence B. Wards 19a, INFORMANT'S NAME (Type/Print)	op Sr.	Lean income			awrence		_		
2						Route Number, City or		iode)		
	Ronald James Day 20e, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo			OF DISPOSITION (N		Del. 1	LOCATION — CI	ty or Town	n, Stata	-
	1 Pariel 2 Cremation 3 Remo		illsbor	other place) Cemeter	v	4/28 M	illsbor	o, D	elaware	
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE			ND ADDRESS OF FA	CILITY				
	Neckard!	Valsor				1 Home,			Delawar	е
	23. PART I. Enter the diseases, or co shock, or hasrt fallura. L	inplications that cause on a lat only one cause on a	d the death. Do ach ilna.	not enter the mo	ide of dying, suc	h aa cardlac or re	apiratory arre	nt,	Approximation interval Better	tween
	IMMEDIATE CAUSE (Final disease or condition	ASC	110						Onsat and	Death
	resulting in dasth)	DUE TO (OR AS A	CONSEQUENCE	OE:	-				4une	ed(
z		Metasta	xic C	er Bla	adder				1/40	` ,
일	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	CONSEQUENCE	OF):						
2	cause, Entar UNDERLYING CAUSE (Disease or injury	A OUE TO OR AS	CONSEQUENCE (ne.					year	>
CERTIFICATION	that initiated events reaulting in death) LAST	Auem		or):					13mo	5.
									-	
¥	PART II. Other algnificant conditions	contributing to death b	out not reaulting	in the underlyin	g cause givan in		AN AUTOPSY FORMED?		WERE AUTOPSY FIN WAILABLE PRIOR T	0
ă						1 □ YES	2 KLNO		COMPLETION OF CA OF OEATH?	AUSE
2	DID TOBACCO USE CONTR	IRLITE TO CALISE C	DE DEATH V	ES I NO I	UNCERTAI	i>Ci∧		1	YES 2 N	0
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	IBOTE TO CAUSE C		ATH (Check only one)		WEN				-
SIC	EXAMINER?	HOSPITAL:	patient 3 DOA	OTHER:	ne 5 🗆 Raeldenca	eV Other (Specify)	Petroly	wt C	rumen 4	7
Ě	27. MANNER OF OEATH	28e. OATE OF INJURY (Month, Day, Year)	28b, Ti	ME OF 28c. IN.	JURY AT	28d. OESCRIBE HO	W INJURY OCCU	RED	(-
BY F	1 Naturel 5 Pending 2 Accident investigation	(Worth, Day, Year)			YES 2 NO					
B	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spe	f — At home, farm, cify)	, streat, factory, offic	00	281. LOCATION (Str. City or Town, St		r Rural Roi	ute Number,	
COMPLET	29a, CERTIFIER 1 SERTIFYING PHYSIC	CIAN: To the best of my know	rledge, death occur	rred at the ilme, date	and place, and due	to the cause(a) and	manner aa steted			
OM	one) 2 MEDICAL EXAMINER	3: On the basia of examination	n and/or Investigat	lon, in my opinion, o	seath occured at the	time, date end place	, and due to the	cause(s)	end menner aa ste	sted.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	, ,			29c. LICENSE NUI	MBER	29d. DATE	SIGNED (Month, Pay, Year)	
TO B	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALISE OF OL	ATH (ITEM 27) (5-	ne Print)	Dag,	769 (M	00 4	12	5/97	1
	NICHOLAS 1	1. BORON	OULIK	1, mo	# (h	n CALAON	77 -	21	811	uej
	31. DATE FILED (MontAPR 2 9 19	97 32. REOS FIAR STEIGH	WHE ROAD	14						



State of Maryland / Department of Health and Mental Hygiene

Hent	OI I	nealli allu	Mentai	nygierie	(
icate	of	Death		40000	

9	7	1	1.	G	France	2
and a	8	-	13	O	J	Ü

	1. Decedent's Nama (First, Middla, Last)
Physician /Medical	IRENE CULI
Examiner	4a. Facility Nama (If not institution, give s

3. Tima of Deeth

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Exercises markes notified as

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use as the bunal-transit Medical Certification

Division of Vital Records, P.O. Box 68760,

1. Decedent's N	lama (First, Mido	dia, Last)							2. Data of Dea			3. Tima of Deeth
	IRENE	CULLUM W	EELING						April	26, 19	Year 97	4:45 PM
		on, give street end num					4b. City, To	wn, or Lo	ocation of Death	4c. County	-	4.40 PM
7846	Creek Sl	hore Way					E	Balti	more		Balti	more
5. Social Securi 213-36-	7973	6. Sax 1 ☐ M 2 ☑ F	7. Aga (In yrs. I 80	ast birthdey) Yrs.	If Undar Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day) June 17	Year)	9. Birthpl Count	aca (State or Foraign try) ryland
Usual Rasidano 10a. Sfeta	e of Dacedant 10b. Count		100 Cit	, Town or Lo						•		-
Marylan		Baltimore		, rown or Lo		alti	more				10	od. Insida City Limits Yes 2 □ No
10e. Street and	Number				10f. Zip	Coda			1	0g. Citizan of	What Coun	fry?
7846 (Creek Sh	ore Way					21226	5			USA	A
	us Married 21€1 Ma ed 4 □ Divorce	Armed For 1 Yes If Yas, Give	XXNo	1	Vas Deced Yes, spec	cify Cub	lispanic Ori an, Maxicer Specify:	n, Puerto	ecify Yes or No- Rican, atc.)		ce - Amarico ck, Whita, a	atc.
3 🗆 AAIGOME			tas:	400 D	diam that	10			ì		Whi	
	15. Deceda Specify only high secondary (0-12)	ent's Education ast grade completed) Collaga (1-	4or 5+)		kind of wo OO NOT us	rk done se retire	during mos d)	t of worki	ing	16b. Kind of B		
17 Eathar's Na	ma (First, Middia	2		H	Iomem	aker		de Maria	(First 14:14)		1 Home	2
	Malcom								(First, Middle, I			
_						101			Carrie			
	n Wheeli	ship (Type, Print) ing, son							ai Routa Number Baltimo			
		3 □Ramoval from S Specify)	CE	ace of Dispo amatary, cran Air M	natory or o	thar ple		ns 4	Data /30/97	20c. Location - Bel Air		
· d	Funeral Service er the Unerlae, o haart fauum Lis	or complicetions thet ce it only ona causa on as	used the death	Ho 13	ward 317 C	K. okes	bury	mas Road	III Fund , Abingo or raspiratory arro	don. M	ame, E Maryla	
Immadieta Cau disaasa or cond rasulting In daa	dition	a. 75	cher	TC 1	HEG	RES	1	Dr.	SGASA	8		YRS
			Dua to (or	es e conseq	uance of):							
Sequentielly list if any, laading to ceusa. Entar U	t conditions, o immadiata	1 b.	Due to (or	as a conseq	uence of):							
Causa (Disaase that initiated ever rasulting in daar	orinjury ants	с	Dua to (or	es e consequ	uance of):							
	,	d										
Dort II. Other al.	-n Minnes on a state	tana arabbahan arab	46.6.44	har to all you			~		and Bills	•		
Di	Sbes	ions contributing to dea	CUA:	iting in the ur	idanying c	eusa giv	an in Pert I	•	1 U Y	V1		the cause of death?
									24a. Was a perform	n autopsy nad?	ava	ra autopsy findings illable prior to apletion of ceusa leeth?
									1 □ Y	s 20 No	10	Yas 2□ No
	efarred to medica	al					26. Place	of Daeth	(Check only on	a) (
axaminar? ¹ 1 ☐ Yas 2	No	Hospital: 1 ☐ In	patienf 2 E	ER/Outpatien	3 DC	A Oth	ar.		ma 5 Rasida	-	er (Specify)
27. Manner of D	eath	28a. Deta of		28b. Time of		8c. Injur Wor			28d. Dascribe ho			,

State Registrar

29b. Signeture end titla of certifie

2 Accidant 3 🗌 Suicida

4 - Homicida

29a. Cartifiar

cause of deeth (Item 23a) (Type, Print)

6 Could not be datarmined

Registrar's Signatura

28e. Place of injury - At homa, farm, straaf, factory, office building, atc. (Spacify)

D15673

Pertifying Physician: To tha best of my knowledga, daath occurred et the time, data and place, and dua to tha ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s)

2003

29c. Licansa number

29d. Data signed (Month, Dey, Year)

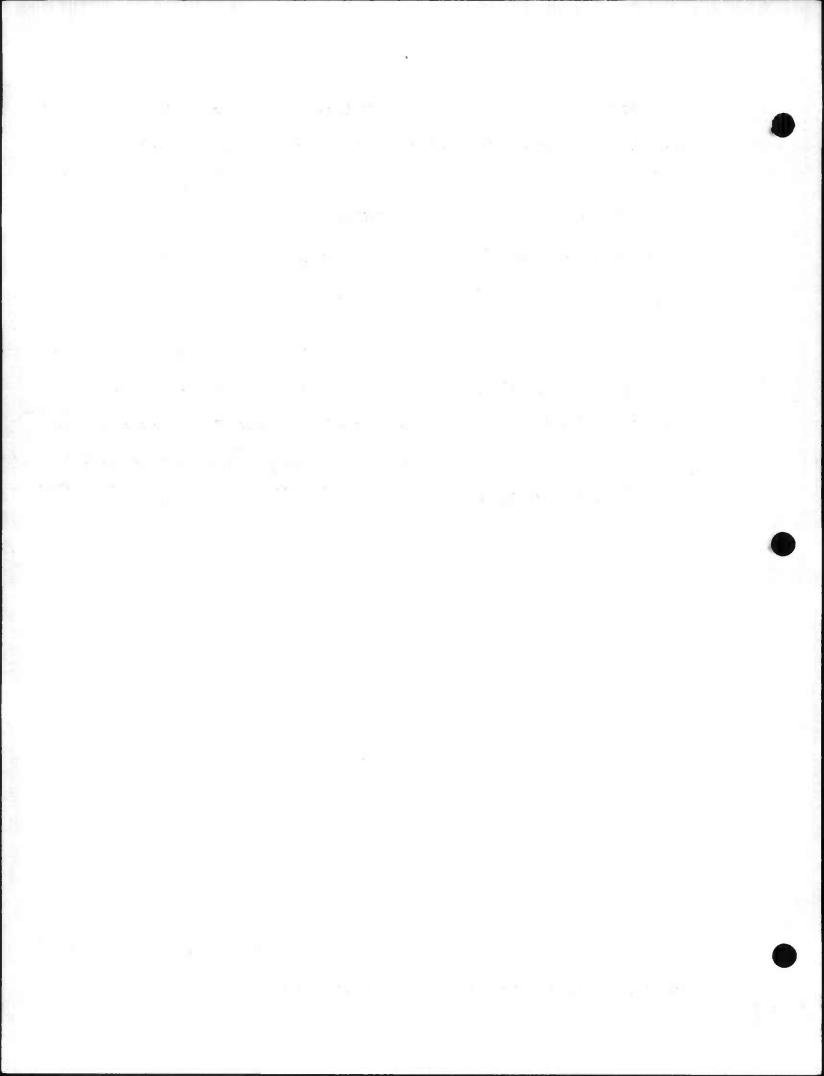
Rock Spring Rd, Forest HII, MD 21050

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete)



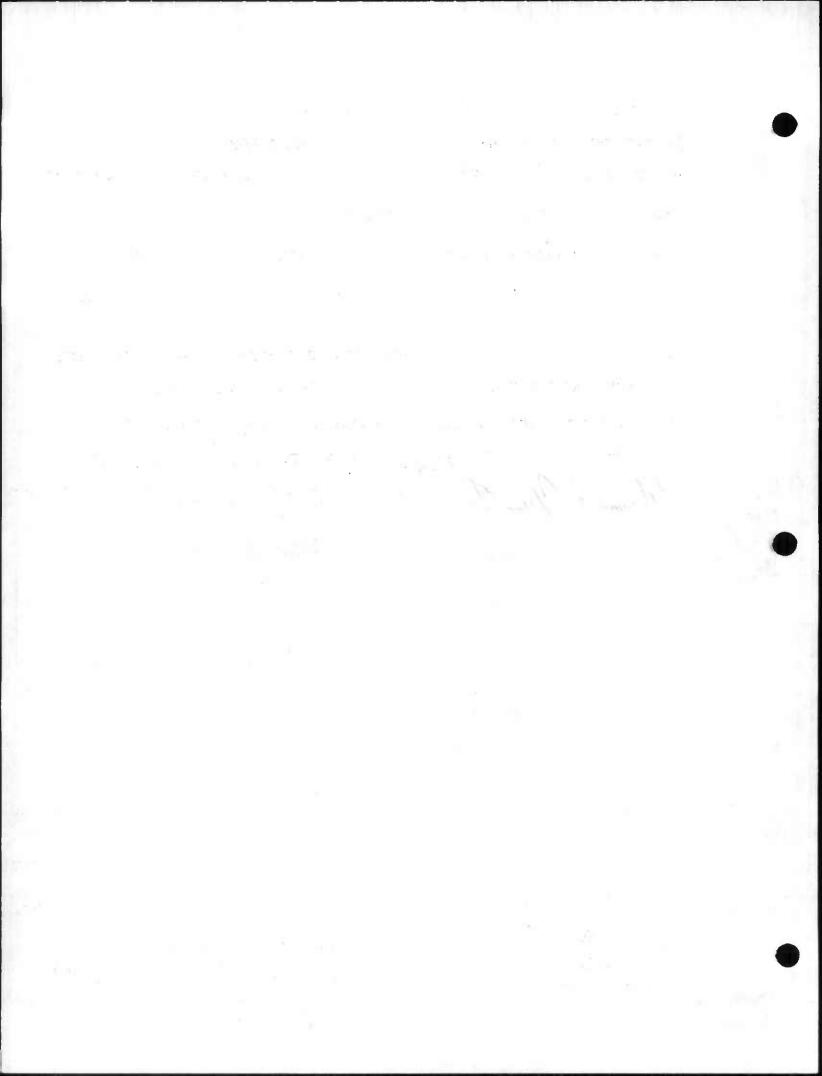
State of Maryland / Department of Health and Mental Hygiene

				State of Maryla		ertificate of			Reg. No.	17	14654
	Dhysisi		1. Decedent'a Neme (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death
	Physici /Medi		HELEN	W_{i}		WICKAR	D		2,1997	real	2:52 AM
	Examir		4a. Facility Name (If not institution, give :				4b. City, Town, or l				500
			Residence-304	North Ce	utre '	street c	cumber		Alle	99N	Y
	Funeral Director		5. Social Security Number 8. Security Number 212 24 2239 Usual Residence of Decedent	7. Age (In yr	s. lest birthde Yrs	Months Days	Hours Min.	(Month, Day	, Year) 5, 19/0	9. Birthpia	ace (Stete or Foreign
	land m		10a. Stete 10b. County	10c. (City, Town or	Location				10	d. Inside City Limits
	Mary	to	Maryland ALLEGA	AA.	(CUMBERLAND					1 Yes 2 □ No
	n the	9	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Count	ny?
	h with	<u>8</u>	304 North CON	tre street	A-3	2/5	02		USA		
020	s 1 end 2 should be filed within 72 hours efter death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23s or 28s-f show other treumstic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Stetus 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:	U,S. 1	3. Wes Decedent of I if Yes, specify Cub		pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Rac	e - America ck, White, e	itc.
9	2 hou	P	**		16a. De	cedant's Usuel Occur	pation		16b. Kind of B		
215-0020	hin 7	Completed	15. Decedent's Educ (Specify only highest grade Elementery/Secondary (0-12)	College (1-4or 5+)	(G.	ve kind of work done DO NOT usa retire	during most of word d)	king			
21	d with	EO	12	College (1-401 54)	F	abric wo	rter		Yarn	& F	abric
pu	ould be filed within Mental Hygiene. arked other than atic event, tre M	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nan				
yla	Ment Ment	2	John William	-				o Min			
Maryland	2 should and Men te marke reumatic		19a. Informant's Name/Relationship (Ty)			ailing Address (Street					
	1 end Health em 27 ther tr		Roy V. Wickard		304	N. CPNTI	re 57, 14	pT,#3	cumbi	onlow	d, Mid.
Baltimore,	Pages nent of H		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	emovai from State	cemetery, o	remetory or other ple	ce)	May	20c. Location -	City or Tov	on, State
tim	nit. Perenting ortant:		4 ☐ Donation 5 ☐ Other (Specify)	51	Pati	Mick's CPH	eeteny 6	119976	-umber	rland	Marylow
Bal	permit. Peges 1 end Depertment of Health Important: If hem 27 any Injury or other th once.		21. Signeture of Funeral Service License Emet a. 1	2		22. Name end Addre Leasure Cum ben				timo	re Ave,
			23a. Part1. Enter the disease, or complie shock, or heart failure. List only on	ations that caused the de	eth. Do not	enter the mode of dyin	ng, such as cardiac	or respiratory er	rest,	1 7	Approximate Interval Between
	Physician					-					Onset and Deeth
	/Medical Examiner	Н	Immediata Causa (Final diseese or condition	CARDI	AC	DYSRHY	THMIA				1 HOUR
	LXummer	_	resulting In death)	Dua to	(or as a con-	sequiance of):	_	~		İ	-
	bed hsit	Examiner	_ b	CORON	IARY	ARTE	RY I	185AS	E	1	8 YZARS
	and al-trar	xar	Sequentially list conditions, if any, leading to immediate	Due to	(or as a cons	sequence of):	/			1	/
68760,	tificete be executed g physician and as the buriel-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or injury that initiated events					- 4		- 1	
89	g phy as the	edical	resulting In death) Last	Due to	(or es e cons	equence of):		//	10		
Box		2	- d					6	ella	117	17/0
	death e ette d for	Physiclan/N	Part II. Other significant conditions con	ributing to death but not re	eulting in the	undertring course of	ton in Part i	220-014	obacco usa co	ntribute to	the cause of death?
P.0	by the destected	hys	~	4			GIT III F GILL.	1 🗆 1			ably 4 Unknown
	signed be def	Бу Р	DIABBTES	3 Mell	119	2			TLDNO		
Records,	been shoul	Completed	Severe	Degener	aTiv	E ART	HRITIS	24a. Was a perfor		com	re autopsy findings Ilable prior to opletion of ceuse eath?
	0 - 0	E O	WITH COT	MPRESSION	, De	FORMITI	of Son	ν≠ 1□ Y	es 200 No	10	Yas 2□ No
Vital	ysician: The s certificate director, pag	Be C	25. Wes case referred to medical examinar?			1 -1 -1 -1 -2	V 3	th (Check only or	ne)		
of V	5 00	To E	Yes 2 No	ospital: 1 ☐ Inpatient 21	ER/Outpat	lent 3 DOA Oth	ner: 4 Nursing H	ome 5 Resid	ence 8 Oth	ar (Specify)	
0	D 9 5		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Data of Injury (Month, Day Year)	28b. Time		y at k?	28d. Describe h	ow Injury occur	red	
Division	al or Attending s after death. al Director: After ed in by the fune	Certification:	2 Accident investigation				Yes 2 □ No				
Ž	fred fred fred fred fred fred fred fred	ŧ	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At building, etc. (Spec	home, farm,	street, factory, office		28f. Location (S City or Tow		er or Rural	Route Number,
	urs a urs a urs a liled										
	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examin	cian: To the best of my kr ar: On the basis of examin	nowledge, de nation and/or	ath occurrad at tha tir Investigation, in my o	na, data and place, pinion, death occur	and dua to tha c red at the time, o	ausa(s) and ma date and place,	nner as sta and due to t	ited. the cause(s)
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	nss		30. Name and address of person who cor				21522				
	Sta	te	DR. S.T. CHANG/FRO 31. Date filed (Month, Day, Year)	36 Redistrar's 90		IDURG, MU.	71JJL				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 4 6 5 5 3. Time of Death Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth

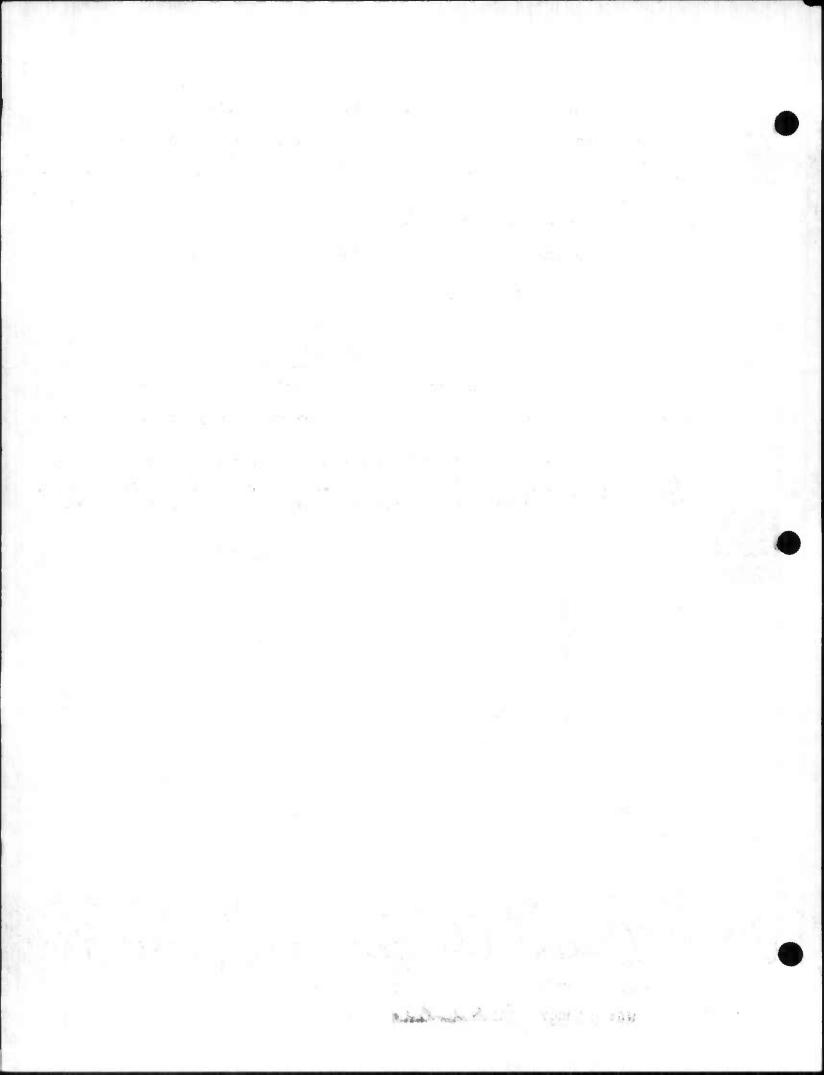
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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate								
П	Physic	an	Decedent's Name (First, Middle, Last)	Dete of Deeth Month Day Yeer							
الم	/Medi		Thomas Whitaker	April 16, 1997 8:13 P.							
	Exami	ner	4a. Facility Neme (If not institution, give street end number)	4b. City, Town, or Location of Death 4c. County of Deeth							
ŀ			Northampton Manor 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Y	Frederick Frederick							
Ł	Funeral Director			fear If Under 24 Hrs. eys Hours Min. 8. Dete of Birth (Month, Day, Year) 8/28/14 9. Birthplece (State or Foraign Country) 5. Carolina							
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	or 28	Director	10e. Street end Number 10f. Zip Cod	de 10g. Citlzen of What Country?							
	ath w	ral	308 ½ N. Jonathan St. 21740								
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9	72 hours "natural",	ted	15. Decedent's Education 16e. Decedent's Usuai Oc	counstion 16h Kind of Business/Industry							
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<u>y</u>	should be filed and Mental Hyg marked other umatic event,	To		Nellie James							
ā			19a. Informant's Name/Raletionship (<i>Type, Print</i>) 19b. Mailing Address (St. 606 E. Pat	traet and Number or Rurel Route Number, City or Town, State, Zip Code) trick St. Frederick, Md. 21701							
	1 P E E		20e. Mathod of Disposition 1 X Buriel 2 Compation 2 Democratics State completely, cremetory or other								
mo	y or		1 KBuriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) Cemetery, cremetory or other Rose Hill Cem								
Baltimore,	그투주를		21 Signeture of Funeral Service Licensee 22. Name and Ac	ddress of Fecility							
8	Depariment on important		Leveld M. Musnich Gerald Funera:	N. Minnich 305 N. Potomac St.							
	Tra in		23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of shock, or heart feilure. List only one ceuse on each line.	1 Home Hagerstown, Md. dylng, such es cerdiec or respiratory arrest, Intervel Batween							
	Physician /Medical Examiner		Immedieta Cause (Finel disease or condition resulting In death) e. Dua to (or as a consequence of):	tic Heart Disease years							
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	sete be executed shysician and the buriel-trensit	edicai Examiner	Sequentially list conditions, Due to (or es e consequence of):								
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of	Physician: r this certific rral director.	2	1 ☐ Yas 2 ☐ Hospitel: 1 ☐ InpatIent 2 ☐ ER/Outpetient 3 ☐ DOA	Other: 4 Nersing Home 5 Residence 6 Other (Specify)							
no	After funer	ion	AA .	Injury et Work? 28d. Describe how injury occurred Work? 1 ☐ Yes 2 ☐ No							
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	To the Hospital or Attanding Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edicai (29e. Cartifiar (Check only one) Certifying Phyaician: To the basis of my knowledge, death occurred et the one) Check only one) Certifying Phyaician: To the basis of examination end/or investigation, in meaning and menner stated.	e tima, data end piece, and due to the ceusa(s) and manner es steted. ny opinion, daeth occurred et tha time, dete and piece, end due to the cause(s)							
	To the To the comp	M	29b. Signature and title of certifier 29c. Lic	sense number 29d. Date signed (Month, Dey, Year)							
			Mayor Y. Chingson	D 16428							
			30. Name and address of person who complated cause of deeth (Item 23a) (Type Fint)	,							
			Casper Cline M. D. 300 W. 9th 31. Dete filed (Month, Dey, Year) 32. Registrar's Signetura	St. Frederick, Md. 21701							
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth April 26, De¥ 997 Jacqueline Delores WILLIAMSON 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 6431 Coffman Farms Road Keedysville Washington 5. Sociel Security Number If Under 24 Hrs. If Under 1 Year 8. Dete of Birth Month Dey, Year) May 7, 1931 7. Age (In yrs. lest birthday) 9. Birthpieca (Stete or Foreign 1□M 2 F Deys Mary Land Months Hours 215-26-8603 65 Usuel Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Keedysville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 6431 Coffman Farms Road 21756 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. 1 Never Married 2 Merried ☐ Yes 2⊠ No Yes, Give white 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorcad Yeer or Detes: 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 0 - 100 senior attendant hospital 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown unknown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 6431 Coffman Farms Road, Keedysville Mr. Robert C. Williamson, Sr. 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a Method of Disposition 20c. Location - City or Town, Stete 1 ⊠ Suriel 2 □ Cremetion 3 □ Removel from State Apr. 29,1997 Hagerstown, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Rest Haven Cemetery 22. Neme end Address of Feclifty Minnich Funeral Home 21. Signeture of Funeral Service Licenses 415 East Wilson Blvd., Hagerstown, Maryland 21740 unning 23e. Per 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth tmmediate Ceuse (Finel diseese or condition resulting in death) cerva Due to (or es e consequenca of) Due to (or es e consequence of): Due to (or es e consequença of): 23b. Did tobacco use contribute to the cause of death? 2 1 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No

Physiclan /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

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Funeral

Director

Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinat manal be notified at

permit. Pages 1 and 2 should be filed within 72 hours after beatment of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural" or health injury or other traumetre.

Maryland 21215-0020

altimore,

P.O. Box 68760,

Division of Vital Records,

death with the Maryland

The law requires that the death certificate be executed and use es the burial-trar attending physician for use es the buria ate hes been signed by the page 2 should be detached certificate hes Hospital or Attending Physician: Medical Certification: To this the funeral After t death. To the Hospital or Attendition within 24 hours after death.

To the Funeral Director: A completely filled in by the fi

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Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last Physician/Medical Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. þ Completed 25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of tnjury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.
2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner steted. 29e. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 4.29 97

D32518

State Registrar

Guedenet

31. Dete filed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

32. Registrer's Signeture

Delting

DHMH 16 Rev 6/95

Name of the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 658 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** 07:37 AF Linda Lee WAHLER 26, Poni /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Washington County Hospital Washington Hagerstown If Under 24 Hrs. If Under 1 Year 8. Dete of Birth (Month, Dey, Year) March 2,1944 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funerai** Days 1□M 2⊠XX Months 53 220-42-6032 Yrs. Director Maryland Usual Residence of Decadent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examiner must be notified at Director Maryland 1 ☐ Yes 2 ☐ No Washington Williamsport 10e. Street end Number Apt 4K 10f. Zip Code 10g. Citizen of What Country? Milestone Garden Apts 21795 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours effer death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23 any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must apprize Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11 Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bieck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ♣ No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 white 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) 0-12 College (1-4or 5+) homemaker own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Bernard L. Toms Marilyn L. Kennedy 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John R. Wahler Milestone Garden Apt 4K, Williamsport, Maryland 21795 20b. Plece of Disposition (Name of cametery, cremetory or other placa) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel trom Stete Rest Haven Cemetery Apr. 29,1997 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home 21. Signeture of Funeral Servica Licenses 415 East Wilson Blvd., Hagerstown, Maryland 21740 innu 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart teilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final neemonia disease or condition resulting in deeth) Examiner Physiclan/Medical Examiner difease menary Obstructi sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury physician that Initieted events resulting In deeth) Lest use as the Due to (or as a consequence ot): for use as Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 6 1 Ves 2 No 3 Probably 4 Unknown signed b ð 24b. Were eutopsy tindings aveliable prior to completion of cause of deeth? page 2 should Completed 24e. Wes en eutopsy performed? 1 Yes 2 LANG 1 ☐ Yes 2 ☐ No Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred After 5 Pending investigation 1 Natural

Box 68760. P.O. | Records. of Vital Division or Attending To the Hospital or Attendent within 24 hours after deat To the Funeral Director:

6 Could not be determined 28e. Place of Injury - At home, tarm, street, tectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Yeer)

29b. Signature end title of cartifier

2 Accident

3 ☐ Suicide

1 ☐ Yes 2 ☐ No

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

4140 -1

ABDUL WAITERD, UD - 12821-OAKHILL AVE. HAGERSTOWN. MD 31. Date tiled (Month, Day, Year)

State Registrar

APR 281997



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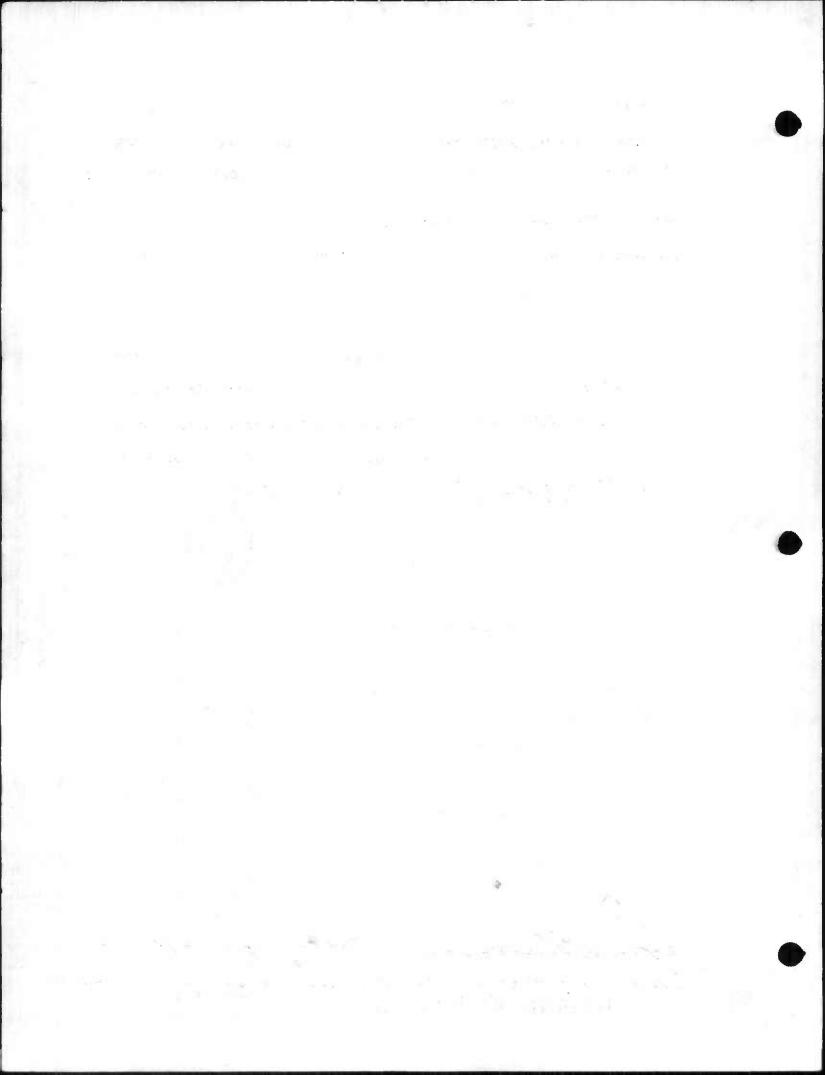
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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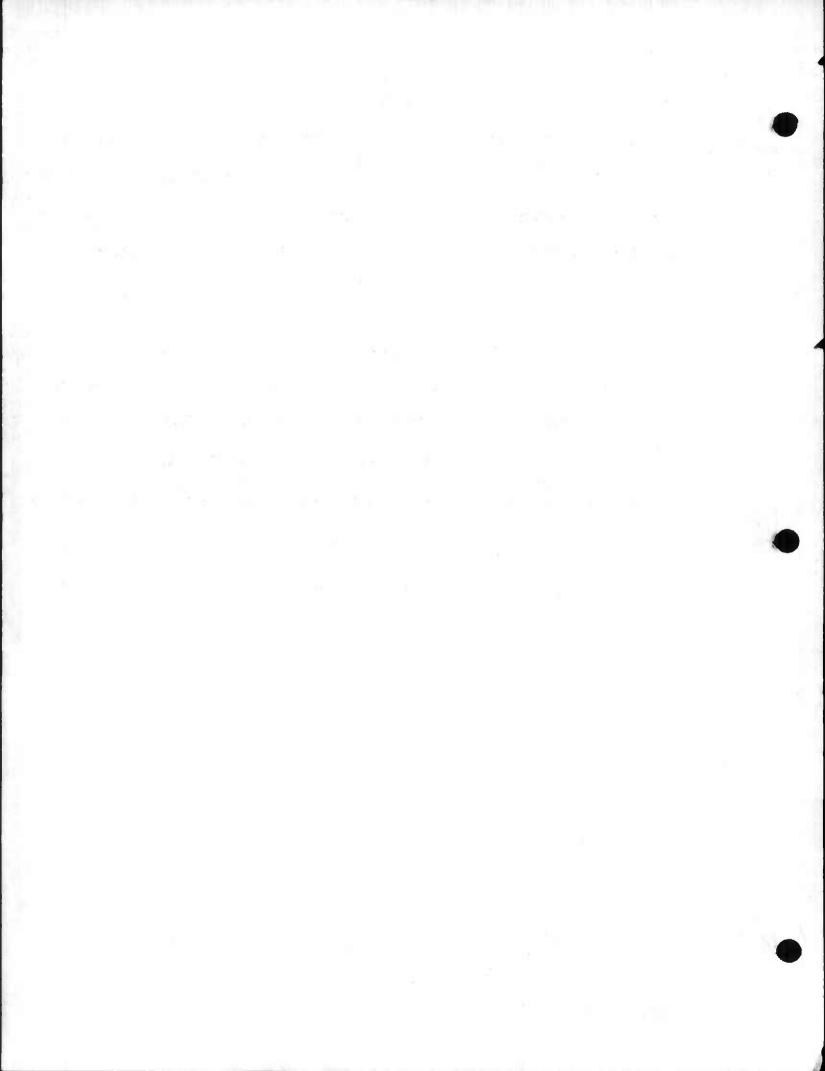


State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

Substitution of the Completed by Funeral Director To Be Completed by Funeral Director	(Specify only high	inon, give street and noimore Medi 6. Sax 1 M 2 F imore ok Rd. 12. Was December of Married Parried Sed Sar Sed Sed Sed Sed Sed Sed Sed Sed Sed Sed	7. Aga (In yrs. 84 10c. Cit Coccedent Ever in U. orcas? 2 No iva Datas: WW]	lest birthday) Yrs. y, Town or Lockeysv:	Months Da	4b. City, Town, or Lo TOWSON Itar If Under 24 Hrs. ys Hours Min. Itar If Under 27 Hrs. Of Hispanic Origin? (Sp. John, Maxican, Puarlo	8. Data of Birth (Month, Day, July 17	Day 12 1 4c. County Balti Year) 1912	yaar 1997 yof Death More 9. Birthplac Country Mary I	Insida City Limit 1 □ Yas 2 N 7
d other than 'natural, state and or 22a-t show of other than 'natural, state and or or other than 'natural and or or other than Medical Estimate must be notified at or or other than Medical Estimate must be notified at or other than the completed by Funeral Director	4a. Facility Nama (If not institute Greater Balt: 5. Social Sacurity Number 705-10-4557 Usual Rasidance of Decedant 10a. Stata 10b. Coun Balt: 10e. Straat and Number 601A Cranbroo 11. Marital Status 1 Navar Married 2 Marital Status 1 Navar Married 2 Marital Status 1 Navar Married 2 Marital Status 1 Secondary (0-12) 17. Father's Nama (First, Middle Elwood 19a. Informant's Name/Ralation	imore Medi 6. Sax 1 M 2 F hty imore Dk Rd. 12. Was De Armed F 1 M Yas, G Yas, G Yas or or earl's Education hast grada complated () Collaga + Z a, Last)	omber) Cal Cent 7. Aga (In yrs. 84 10c. Cit Coc cedant Evar in U, orcas? 2 \(\sigma \) No iva Datas: WW]	lest birthday) Yrs. y, Town or Lockeysv:	If Undar 1 Ye Months Da Dacation ille 10f. Zip Cod 21030 Was Dacadant of Yas, specify C	4b. City, Town, or Lo TOWSON Itar If Under 24 Hrs. ys Hours Min. Itar If Under 27 Hrs. Of Hispanic Origin? (Sp. John, Maxican, Puarlo	8. Data of Birth (Month, Day JULY	4c. County Balti Year) 1912 Og. Citizan of N	of Death MOTE 9. Birthplac Country MATY I 10d. What Country USA ce - Amarican	and Insida City Limi 1□Yas 2巻N 7
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a mari			Lee	Ar	nderson	Cather		E.	Coll	ier
727			ife)			aat and Number or Run OOK Rd. Coo				da)
important: if lean 27 and injury or other tra	20a. Mathod of Disposition 1 □ Burial 2 ☎ Cramation 4 □ Donation 5 □ Other		Canan	amatary, crar	osition (Nama of matory or other Service	placa)	Data -14-97	20c. Location -	City or Town,	Stata
importa any inju	21. Signatura of Funaral Sarvio	De Licans		22	Nama and Ad Ruck 1050	drass of Facility Towson Fun York Rd. T	eral Horovson, N	me, Inc. Md. 212	04	
/sician ledicai	23a. Part1. Enter tha disaasa, shock, or haart failura. Li Immediata Causa (Final disaasa or condition rasulting in death)	a.	Cron	ras a conseq	Arto	m D18			ini Or	pproximata tarval Batween nsat and Death
as th	Sequantially list conditions, if any, laading to immadiata cousa. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last	b c		r as a consaq r as a consaq						
od for	Part II. Other significant condit	tions contributing to d	laath but not rasi	ulting In tha u	ndarlying causa	givan in Part I.	23b. Did to	bacco usa co	ntributa to the	s causs of dea
be deteched for use by Physiclan/N										ly 4 Unkn
should should ieted							24a. Was as perform	n autopsy nad?	availal	autopsy finding bla prior to lation of causa hth?
director, page 2							1 □ Ya	s 2 No	1 🗆 Y	as 2 No
rector, pag	25. Was casa rafarrad to medic axaminar?		7			26. Placa of Daat	(Check only on	a)		
年回 つ	- Hoepital: /						ma 5□ Rasida 28d. Dascribe ho			
within to the Funeral Director: After the completely filled in by the funeral Medical Certification:							28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata)			
To the Funeral completely filled C	29a. Cartifiar (Check only one) Certify	al Examinar: On tha b	a best of my know easls of axaminat	wledga, daath tion and/or inv	occurred at the vastigation, in m	a tima, data and place, ry opinion, daath occurr	and dua to tha ca ed at tha tima, da	usa(s) and ma ata and placa,	annar as state and dua to the	d. a causa(s)
Ne Me	29b. Signature and title of certifi		0		29c. Lica	ansa numbar	25	9d. Data signe	d (Month, Day	, Yaar)
	hat	- Cour	la		1	-12950		May 1	3, 199	7
3	30. Nama and widrass of perso	n who completed cau	sa of daath (Itam	23a) (Type,	Print)	< RD	Tores			

DHMH 16 Rav 6/95

1991 - 1938

State of Maryland / Department of Health and Mental Hygiene

				State of W	iai yiai i			of Death	i Wellal Hy	Reg. No.	97	14662		
	Physic		Decedent's Name (First, Middle, La		rine	J. Angs	st		2. Dete of De Month	eath Day	Yeer 997	3. Time of Deeth		
	/Medi Exami		4e. Fecility Name (If not institution, gir				-	4b. City, Town, o	or Location of Deat			1:58 P.M.		
			100 Governor'	s Court Ap	ot. K			Glen Bu	rnie	Anne	e Aru	nde1		
	Funeral, Director		215 07 2485	Sax 7. Ag 1 □ M 2 1 7 F	ge (In yrs.	lest birthdey) Yrs.	If Under 1 Ya Months Da			rth ey, Yeer) , 1917		ece (Stete or Foreign try) Land		
	and with		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	ation				10	Od. Inside City Limits		
	n the Marylan r 28e-f show notified at	ō	Maryland Anne Ar	undel		en Bur						1 ☐ Yas 2 No		
	r 28a	rec	10e. Street end Numbar				10f. Zip Cod	e		10g. Citizan of 1	What Count	try?		
	23a or	a D	100 Governor's	Court Apt	. K		21	061		U.S	3.			
020	urs after doa M', or Hama Examinar m	by Funeral Directo	11. Marital Status 1 □ Naver Married 2 □ Marriad 3 ☑ Widowed 4 □ Divorced	12. Was Decedant Armed Forces' 1 ☐ Yes 2 ☑ If Yes, Give Yaar or Dates:	ces? If Yes, specify Cuben, Mexican, Puer 2 ☑ No 1 ☐ Yes 2 ② No Specify:				(Specify Yas or No erto Rican, etc.)	pecify Yas or No- Rican, etc.) 14. Reca - Amarican Indian, Black, Whita, atc. Specify: White				
PIN S	han 'natur	Completed	15. Decedent's E (Specify only highest gn Elementary/Secondary (0-12)	5+)	(Give k life. D		ne during most of w tired)	vorking	16b. Kind of Business/Industry					
100	*	ပိ	7th Home Maker 17. Fathar'a Name (First, Middle, Last) 18. Mother's Ner							Own Home leme (First, Middle, Maiden Surneme)				
E	O Di Santa	To Be	V	Villiam J.	Mart	in			Henrietta					
Mary	and A and A arms		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or 1									Code)		
	F 1 and 3 (Health trem 27)		Dennis P. O'Too	Kawshe		Hanove	r, Maryl	and 2	21076					
0	80=5		20a. Method of Disposition 1 □ Burlel 2 □ Cremation 3 □	Removal from State			ition (Neme of etory or other		Date	20c. Location -				
Baltimore,	permit. Pa Departmen Important: any injury once.		4 ☐ Donation 5 🖾 Othar (Specif	y)Entombmer	it St.			-	5/14/97	Cincinn	ati,	Ohio		
Bal	Depa Import any ir		21. Signature of Funeral Service Lice	$(\mathcal{E}, \mathcal{L})$	vie	40	01 Rito	dress of Facility chie High	way Bal	Funeral timore,				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdlec or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth											
<i>.</i>	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in deeth)	Chronic	Rena.	l Failu	re					3 years		
	pa ii	Examiner		Coronary		es a consequency Dis					1	12 years		
	ificate be executed g physician end as the burial-transit	хап	Sequentially list conditions, if eny, leading to immediate			es e consequ								
68760,	sician burit		Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Causa (Disease or Injury that initiated avents	Essentia							2	20 years		
	E 00 00	Medical	resulting in death) Last	Diabetes		as a consequ Litus T					1	7 years		
Вох	that the death certific ed by the attending p deteched for use as	Physician/R		0.							I			
P.O.	the de	ysic	Part II. Other significant conditions of		ut not resu	Iting In the und	derlying ceuse	given In Pert I.				the cause of death?		
<u>م</u>	es that igned by	by Pr	Mitral Regurgitation							Yes 28 No	3 Prob	ably 4 Unknown		
of Vital Records,	The law requires that the death cer ate has been signed by the attendin page 2 should be deteched for use	Completed b	Chronic Obstra	24a. Wes	en eutopsy ormed?	ra autopsy findings llable prior to apletion of cause eath?								
E B		EOC							1 🗆	Yes 2 No	1 🗆	Yes 2□ No		
/ita	ician: The certificate rector, pag	Be	25. Wes cese referred to medical examiner?						eath (Check only	one)				
of	this aldi	10	1 Yes 2 No			ER/Outpetient	3LI DOA		Home 5 Rasi)		
ion	After After	ation	27. Manner of Deeth ↑□ Natural 5 □ Pending 2 □ Accident investigation	1	28e. Dete of Injury (Month, Dey Year) 28b. Time of Sec. Injury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No				28d. Describe	28d. Describe how injury occurred				
5	tal or Attendins efter deatl	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or A within 24 hours efter To the Funeral Direct completely filled in the funeral or the formula or the following the filled in the funeral or the filled in the filled	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Ph	yalcian: To the best of niner: On the basis of end manner sta	examineti	viedge, death o on end/or inve	occurred at the estigation, in m	time, date and place y opinion, death occ	ce, end due to the curred at the time,	cause(s) and ma date and place,	nner as ste	eted. the ceuse(s)		
	To the To the comple	×	29b. Signature and tipe of certifier	jura	- M	hysici	an)	D14160		29d. Data signed 05/12/		ay, Year)		
	3		30. Name and address of person who harjit Singh, N					, Dal±2	EM ovo	21225				
V	Sta		31. Date filed (Month, Dey, Year)	32. Registra	ar's Signati	ure	itialima	y Baltim	ore, Ma.	21225				

DHMH 16 Rev 6/95

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BALTIMORE, MARYLAND 21215-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYGIEI		
	1. DECEDENT'S NAME (First, Middle, Last)	7)	,			2. DATE OF DEATH MONTH	DAY YI	3. TIME OF DEATH
	204NAIE	BEASIEY				05 /	10 9	7 11:40 AM
	254-18-9689	ØM2□F	yrs. last birthday) YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country) GA
Œ	99. FACILITY NAME (If not institution, give stree	t end number)		//	MARE	ATH	9c. COUNTY	
310	RESIDENCE OF DECEDENT	~		DAKII	munc,	1119.	INA	
DIRECTOR	100. STATE 10b. COUNTY	NA	10c. CITY	TOWN OR LOCAT Baltin				10d. INSIDE CITY LIMITS? XX YES 2 NO
AL	10e. STREET AND NUMBER			100	. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	3040 Barclay St				21218		USA	1
BY FUI	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	P. WAS DECEDENT EVER IN I FORCES? 1 TYPES IF YES, GIVE WAR OR DAT	2 NO	If yes, sp	ENDENT OF HISPAN acity Cuben, Mexica 2 NO Specify	IIC ORIGIN? (Specify Yon, Puarto Ricen, etc.)	na or No — 14.	. RACE — American Indien, Black, White, etc. Specify: Black
ED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	ION	Ida. DECEDENT'S U	SUAL OCCUPATION	ON	16b. KIND OF BI	USINESS/INDUST	
Ē	Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	_	st or working			
COMPLETED		IA	Iron R	lod				oint Corp.
BE CO	17. FATHER'S NAME (First, Middle, Last) John D. Beas	sley			Berth		Wi	nford
6	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or To		
	Mattie Beasley		LACE AND DATE OF				OCATION - City	Md. 21218
	1 Spurial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	From State of mic	Baltimo	orphical Cen	. 05-15	5-97 Ba		ce, Md.
	21: STONATURE OF FUNERAL SERVICE LICEN		DOL CLIIIC					Maryland
	Maldi Hall	ner Wh.	10					North Avenue
	23. PART I. Enter the diseases, or com	pilcstions that caused t	the death. Do no					
	ahock, or heart failure. Lis IMMEDIATE CAUSE (Final	t Dnly one ceuse Dn eac	th line.					interval Between Onset and Death
	disease Dr condition reaulting in death)	ACUTE DUE TO (OR AS A C	ONSEQUENCE OF	PIRATU	1	AILUR		5.000
z		1511 AT	ERAL	MEa	RAL E	FFUSSIO	n	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	,	y	10-	1		
5	CAUSE (Disease or injury	DUE TO (OR AS A C	-I NON		FORd.	STATE		
Ē	that initiated events resulting in death) LAST	DOE TO (OH AS A C	ONSEGUENCE OF	i				
	d							
M	PART II. Other significant conditions of	ontributing to death but	not resulting in	the underlying	cause given in	Part I. 24a. WAS AI PERFO	N AUTOPSY PRMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ğ						1 YES	2 NO	OF DEATH?
M	DID TODA CCO LICE CONTROL	VITT TO CALLET OF	DEATH 1/2					1 - YES 2 NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB		DEATH YES		UNCERTAIN	11/41		
SIC		OSPITAL:		OTHER:	s 5 🗆 Residence	A 17 OH 18 18 18 18 18 18 18 18 18 18 18 18 18		
Ä	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME	OF 28c. INJ	URY AT	28d. DEŞCRIBE HOW	INJURY OCCUR	ED
ВУ Р	2 Accident 5 Pending Investigation	(Month, Day, Year)	INJU		RK? 'ES 2 NO			
	3 Suicide 6 Could not be	28a. PLACE OF INJURY - building, etc. (Specify	At home, farm, st	reet, factory, offic	ē.	281. LOCATION (Street City or Town, Stets	end Number or F	Rural Route Number,
ETE	4 Nomicide datermined			_		Only of lown, office	,	
P.		N: To the best of my knowled						
COMPLETED	2 MEDICAL EXAMINER: (On the basis of axemination of	and/or investigation	, in my opinion, d	eath occured at the	time, date end placa, e	nd due to the cr	nuse(a) and manner oa stated.
BE (BOD STORMTURE AND TOTLE OF CERTIFIER	3			29c LICENSE NUM	IBER	29d. DATE SI	GNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHIS C	OMPLETED CAUSE OF DEAT	H (ITEM 27) (Tex	Defeat)	114	100	1-1.60	7/21/7]
	MADURA L'YR	ABHA KAR	MO.	21150	LOORS	MS ROAD,	BAC	TIMORS MO 21220
	31. DATE FILED (Month, Day, Year) MAY 1 4 1997	32. REGISTRAR'S SIGNAT	WAE TO THE LAND					

- Property of the second

Fig. 12 To 12

State of Maryland / Department of Health and Mental Hygiene 97

29d. Data signed (Month, Day, Year)

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									Reg. N	10.			
		1. Decedant's Nama (First, Middle,	Last)					2. Data of	Death		Marilla .	3. Tima o	f Death
hysicia/ Medica/		ROPER		BILES	S	JR.		Month MAY	0.9	9 1	997	4:29	P.M.
/Medica Examine		4a. Facility Neme (If not institution, g	riva street and numb	er)			4b. City, Town,	or Location of De		c. County	-	1.27	1 . 11.
	"	SAINT JOSEPH	MEDICAL.	CENTE	מה		TOWSON	MARVI.A	ND I	BALT	TMOE	ਸ	
ineral					last birthday)	If Under 1 Yas	r If Undar 24 H					laca (Stata	or Foreign
rector		245-38-4270	M 2□ F	65	Yrs.	Months Day	s Hours M	in. 8. Dete of (Month, 05 –	Day, Year	32	Coun	itry)	
		Usual Rasidance of Decedant						- 05	0 0		N	C.	
the Medical Examiner must be notified at		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					1	0d. Insida C	Ity Limits
Die C	to	Md NA			Balti	more						1 X Yes	2□No
got .	Director	10e. Street and Number				10f. Zip Code			10g. C	Itizen of W	Vhat Coun	itry?	
		2036 Cecil Av	renue			2121	9		r	JSA		•	
	Funeral	11. Marital Status	12. Was Decede	ent Evar in U	l.S. 13. V			(Specify Yas or			a - Americ	an Indien.	
	2	1 ☐ Never Married 2 ☐ Married	Armad Force	as?	II	Yas, specify Cu	Hispenic Origin? ban, Mexican, Pu	arto Rican, atc.)			k, Whita,		
	þ	3 ₩ Widowed 4 Divorced	If Yas, Giva Year or Data		1	Yes 2 N	Spacify:			Specify:	B1	ack	
	8	15. Decedant's			16a Deced	lant's Usual Occ	unation		16b I	Kind of Bu		-	
leo.	Completed	(Spacify only highast g	rade complated)		(Giva	kind of work don OO NOT usa ratii	upation a during most of 1 ed)	vorking	100.1		0000	Justiny	
8	E	Elamentary/Secondary (0-12) 12th Grade	NA	or 5+)		pervis			Be	thle	hom	Stee	1 00
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29c. Licansa number

7505 OSLER DRIVE SUITE 306, TOWSON, MARYLAND

D23045

State Registrar

29b. Signature and the of comifian

30. Name and address of person who complated causa of daath (Itam 23a) (Type, Print) LINCOLN M.D.,

DHMH 16 Rav 6/95

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State of Maryland / Department of Health and Mental Hygiene

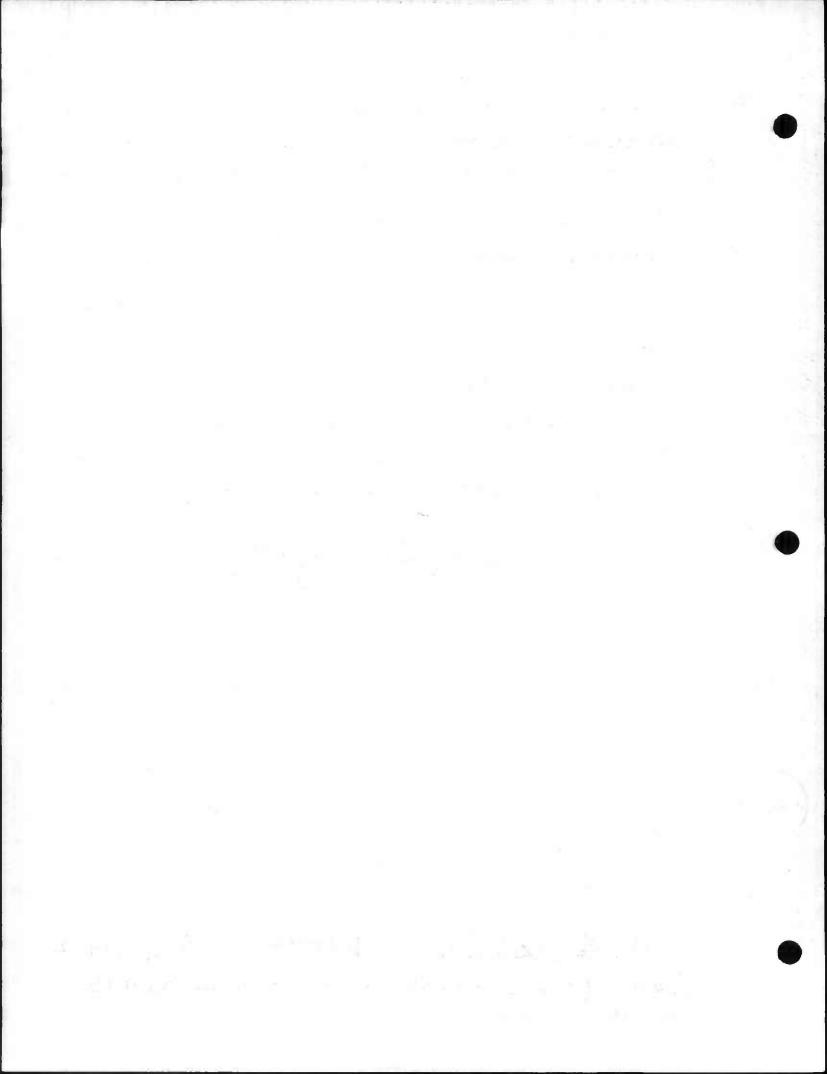
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od in by		3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicida datarmined	28a. Place of Injury - At building, etc. (Spec	home, farm, stre ify)	eat, factory, offica		28f. Location (5 City or Tow	itraat and Numbe n, State)	r or Aurai Ad	outa Number,
within 24 hours after death To the Funeral Director: A completely filled in by the f Medical Certificati	2	29a. Cartifiar 1 CertifyIng Phy (Check only one) 1 Medical Exam	sician: To the bast of my kn iner: On the basis of exemin and mannar stated.	owladga, daath etion and/or inv	occurred at tha tir restigation, in my o	ma, data end plece, pinion, daath occur	, end dua to tha c rred at tha tima, c	ausa(s) and man late and place, ar	nar as state nd due to the	d. a causa(s)
To th comp	2	9b. Signatura end title of certifiar **Xoque**	m.D.		29c. Licans	a number		29d. Dete signed 5 - 9 -		, Year)
8	3	O. Nema and eddress of person who of	ompleted cause of death (Ite	am 23e) (Type, F		VERAL	HXSPI	TAI		
State	3	Data filed (Month_Day, Year)	32. Ragistrar's Sign	ature		(\())	HOOLI	- 7 Films		
Registrar		MAY 1 11	997 Delia	Twister &	Dad as					
46 Day 605	_		0		THE REAL PROPERTY.					

DHMH 16 Rav 6/95



	- 1	1. Decedent's Name	(First, Middle), Last)		O G I	tificate of	Dealli	2. Date of Dea	Reg. No.	- 1	3. Time of Death
Physic /Medi		Miria	am	,	E.		Blank		Month May 10	Day 1997	Year	3 PM
Exami	ner	4a. Facility Neme (If						4b. City, Town, or I	ocation of Deeth	4c. County	of Deeth	
		3041 Fall			202D			Baltimor	_	N/		
Funeral Director		5. Social Security Nu 213-42-33	394	6. Sex 1 □ M 2XXF	7. Age (In yr. 85	s. lest birthdey) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, De) March			ece (Stete or Fore ry) rland
show		Usuel Residence of t 10e. Stete	10b. County		10c. C	City, Town or Lo	cation				10	d. Inside City Lim
the Man	Director	MD	N,	/A		Baltim	ore					MYes 2□
a or 2		10e. Street end Num					10f. Zip Code			10g. Citizen of V		ry?
ms 23a	era	3041 Fall	Istaii		202D	11 12 12	Vac Decedent of h		posify Ves or No		A. America	on Indian
or its	by Funeral	1 ☐ Never Merrie	_		cedent Ever In Forces? 2 2 No Give Dates:		Yes, specify Cub	lispanIc Origin? (S en, Mexican, Puert Specify:	o Rican, etc.)	Specify	k, White, e	tc.
piene. r than "naturel;	Completed	(Specification (Speci		t grade completed	(1-4or 5+)			petion during most of world)	king	16b. Kind of Bu		
7 70 5	ပိ	17 Enthada Nama (6	Tinat Adiedalla I	l and l		HOI	sewife	40 Mathada Nas	- Office A Adjusted		n Hon	ne
0 = 0	To Be	17. Father's Name (F Samue)		Last)	Bernst	tein		Sara	ne <i>(First, Middl</i> e, h		_{e)} Jeiner	
and Menters and marked	-	19e. Informant's Nan	ne/Relationsh	nip (Type, Print)		19b. Mailin	g Address (Street	end Number or Ru				
Health ar em 27 is other trau		Dr. Gordon	n Bla	nk (son)	3041	Fallstaf:	f Rd Ar	t 202D,	Baltimo	ore,	MD 21209
Department of Healt Important: If item 2 any injury or other once.		20e. Method of Dispo XX Burial 2 ☐ 4 ☐ Donation 5	Cremation	3 □Removal from	n State	Place of Disposementery, cremetery	sition (Neme of setory or other ple		Dete .1/97	20c. Locetion -		
Departm Importa any inju		21. Signature of Fund	eral Service L	lcensee /	HI.		Name end Addre			Daitin	ore,	riD
hysician /Medicai Examiner	er	23a. Pert1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	inal		Ische		Cardio	Muopa t		ost,		Approximete interval Between Onset and Death
2 76	al Examiner	Sequentially list condition, leading to immoduse. Enter Underlicause (Disease or in	ditions, nediate ying	b		(or as a consequ	uence of):		V			
anding physician and use as the burlai-trans	n/Medical	that Initiated events resulting In death) La		d	Due to (or as a consequ	ience of):					
by the attending physiconed for use as the	-	triat initiated events	ast					ren In Pert i.				
been signed by the attending physishould be detached for use as the	by Physician/Me	resulting in death) La	ast					ren in Pert I.		ee 2□ No	3 ☐ Prob	ably 4 Unkn
se been signed by the attending physical bear as the should be detached for use as the	by Physician/Me	resulting in death) La	ast					ren in Pert i.	1□ N 24a. Was a perfor	2□ No an autopsy med?	3 Prob	re autopsy finding ileble prior to ipletion of ceuse eath?
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se been signed by the attending physical bear as the should be detached for use as the	Be Completed by Physician/Me	resulting in death) Le	eant condition	ns contributing to	death but not re		derlying ceuse glv	26. Place of Dea	1□ N 24a. Was a perfor	an autopsy med?	3 Prob	re autopsy finding ideble prior to upletion of ceuse eath?
th. After materaticate has been signed by the absording physican director, page 2 should be detached for use as the	To Be Completed by Physician/Me	Part II. Other eignific 25. Was case referre examiner? 1 Yes 2 2	eant condition d to medicel O 5 □ Pending investig	Hospital: 1 28a. Date (Mostion)	death but not re	sulting In the un	derlying ceuse gives a second of the second	26. Place of Dea er: 4□ Nursing H	24a. Was a perfor	an autopsy med? es 2 No ne) ence 6 Othe	24b. We ave con of d	re autopsy finding fieldle prior to upletion of ceuse eath? Yes 2 No
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

14667

						Ceru	ncale of	Deal	11		Reg. No.		
	Physici /Medic		1. Decedent's Nama (First, Middle, Las	" Brobst						2. Data of De Month May	ath Pay	Vaar	Tima of Death
	Examir		4a. Facility Name (If not institution, give	street and number)		13		4b. City,	Town, or Lo	ocation of Deati	4c. County	of Death	
			Howard County Ge	neral Hospi	tal			Col	lumbia	1	Hov	vard	
F	uneral		5. Social Security Number 6. Sa		yrs. last birt		f Undar 1 Yaa		ler 24 Hrs.	8. Data of Bir (Month, Da	th	9. Birthplace	a (State or Foreig
	irector		579-48-6345 Usual Rasidence of Decedent	⊒м 2 Х СХғ	84	Yrs.	Months Day:	s Hour	s Min.	Apr. 2	7,1913	Ohio	
ą.	ahow dat		10a. Stata 10b. County	10	c. City, Towr	n or Locat	tion					10d.	Inside City Limit
with the Marylar	notified at	Director	MD Carrol	1	West	mins	-						1□Yes 2KIN
1	1 00	al Dir	10a. Street and Number 3795 Baker Road				10f. Zip Code 21157				10g. Citizen of USA	What Country	
1	150	uneral	11. Marital Status	12. Was Decedent Evan	In U,S.	13. Wa	s Decedent of	Hispanic	Origin? (Sp	ecify Yas or No Rican, etc.)	- 14. Rac	ce - American	
I	IH)	by Fu	1 Nevar Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes ŽŽXNo If Yes, Giva Yaar or Dates:			as, specify Cu Yes XXN			Hican, etc.)	Specif	ck, White, etc. Whi	
18	1	leted	15. Decedent's Edi (Specify only highest grad	ucation da co <i>mpleted)</i>	16a.	Deceden (Give kin	t's Usual Occi d of work don NOT use retir	upation e du <i>ring</i> m	ost of work	ing	16b. Kind of B	usiness/Indusi	try
d within	The M	Completed	Elamantary/Secondary (0-12)	College (1-4or 5+) 2+						istrato	r Med	ia Sur	vey
belli e	othe ent	Be C	17. Fathar's Name (First, Middle, Last)		,			18. Mo	ther's Name	e (First, Middle,	Maiden Sumar	ne)	
Month!	merked matic ev	To B	Jay H. Vaughan					Має	e Titu	ıs			
fi ?	9 5	-	19a. Informent's Name/Relationship (T	ype, Print)	19b.	. Mailing /	Address (Stree	et and Nun	nber or Run	al Routa Numb	er, City or Town	, State, Zip Co	de)
and 2			Robert J. Brobst	/Son	37	795 E	Baker R	oad,	Westn	ninster	, Mary	land 21	157
27	Item 27 other t		20a. Method of Disposition		Ob. Piece of	Dispositi	on (Name of ony or other p	ace)	1	Data	20c. Location	- City or Town,	State
Pages ant of	T O		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Othar (Specify)	Removal from State			-Washin		Cr.	5/13	Laurel	Maryl	and
Denmit, Page	important: If It any injury or o		21. Signature of Funeral Service Licens	000			lama and Add			ne, Inc			
	ledical aminer	34	Immediete Cause (Finei disease or condition resulting in death)	· Pneumo	M C to (or as a c	consequa	nce of):					1	lays
petno	ansit	Examiner	Sequentially list conditions	b. COPD	to (or as a c	conseque	nce of).					Y	ears
be exec	ician an burial-tr		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	C	Ì								
certificate be executed	nding physician and use as the burlal-transit	n/Medical	rasuiting in death) Last	Due	to (or as a c	onseque	nce of):						
	for	Physician	Part II. Other significant conditions co	ntributing to death but no	t resulting In	tha unda	irlying cause o	iven In Pa	rt I.	23b. Dld	tobacco use co	entribute to the	cause of death
that the	ed by detac									150	108 2□ No	3 Probeb	ly 4 Unknow
ne law requires that tha death	as been s 2 should	Completed by								24a. Was perfo	an autopsy rmed?	availal	autopsy findings ble prior to etion of cause th?
The law	ate h	00								10	Yes 210 No	1 U Y	as 20 No
an:	is certificate hadinector, page	Be (25. Was case referred to medical examiner?					26. Pla	ace of Deat	h (Check only o	one)		
Physician:		T _O	1 Yas 2 No	Hospitai: 1 Ampatient	2 ER/Out	tpatient	3 DOA	ther: 4 🗆	Nursing Ho	me 5 Resi	dence 6 Ott	nar (Specify)	
	After th funeral		27. Manner of Death 1 SNatural 5 □ Pending	28a. Data of Injury (Month, Day Yea	28b. T	ima of	28c. Inj W	ury at ork?		28d. Dascribe	how Injury occur	rred	
Attending or death.	£ 0	Certification:	2 Accident Investigation 3 Sulcide 6 Could not be 4 Homicide determined	28e. Piace of Injury -	At home, fai		M 1[Yes 2	-	28f. Location (Street and Numi	ber or Rural Ro	oute Number,
Hospital or A	To the Funeral Direct completely filled in by			building, etc. (S)		death or	curred at the	time dete	and place	City or To		ennor es etato	d
	To the Fun completely	fedical	one) 2 Medical Exami	ner: On the basis of exa and manner stated.	minetion and	d/or inves	tigation, in my	opinion, d	leeth occurr	ed at the time,	date and place,	and due to the	cause(s)
To the		×	296. Signature, and title of certifier	Gruss	1			(19	them.		29d. Date signe May	10 19	19'7
	10		30. Name and address of person who	onsteted cause of death	(Item 23e) (Type, Pri	nt) Oblis P	dS	442	ON Ell	licott G	ty Mi)

State Registrar

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" AND THE STATE OF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Dete of Death Month Year GREGORY L. BUSH MAU 1997 1:00 AM 4a. Facility Name (If not institution, give streat and number) 4b. City. Town, or Location of Death 4c. County of Deal HOSPITAL SINA BALTIMORE If Undar 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Aga (In yrs. last birthday). Yrs. 6. Date of Birth (Month, Day, Year) 3-5-59 Birthplace (State or Foreign Country) 216-74-3107 Usual Residence of Dacedant 10b County 10d. Inside/City Limits 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 52 12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Biack, White, atc. 1 Never Married 2 Married 1 Yes 20 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coilege (1-4or 5+) indary (0-12) STOCK Labores 17. Fathar's Name_I (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) 19a. Informant's Name/Relationship (Type, Pnint) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LTIMORE, MD 2/2/5 20b. Place of Disposition (Name of cemetery, cremetory or other pla 20a. Method of Disposition 20c. Location - City or Town, State Data 1 D Bunal 2 Cremation 3 Removal from Stete 5-16-97 Catonsville, MD PERT D. WILLE FUNER 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility // N.GILHOR STREET. 23a-Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disaasa or condition resulting in death) DNEUMONIA 1- Z weeks Due to (or es e consequence of): ASPIRATION Due to (or es a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? cardromyopathy, 1 Yee 2 No 3 Probably 4 Unknown Hepotic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 26. Piece of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify)

Physician Examiner

physician and s the burial-tren

signed by t

þ

Completed

Certification: To

Medical

The law requires that the death certificate be executed

Records, P.O. Box 68760.

Division of Vital or Attending Physician:

Baltimore, Maryland 21215-0020

Hygiene.

s 1 and 2 should be filed w f Health and Montal Hygien fam 27 is marked other th

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tran

Pages 1 and 2 should

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In death) Last

27. Manner of Deeth

1 Natural 2 Accident

3 Suicide

25. Was cesa referred to medical examiner? Hospital: 1 Unpatient 2 ER/Outpatiant 3 DOA 1 Yes 2 No

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

MAY 13.

(Check only one) 29b. Signature and Min of

AUEN

5 Pending Investigation

12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, end due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

M.D

SINAI HOSPIOTAL, BOLLIMORE, MD

A52402321-67A-9063

Registrar

31. Date filed (Month, Dey, Yeer)



DHMH 16 Rev 6/95

within 24 hours effer death.

To the Funeral Director: After thi
completely filled in by the funeral

the th



97-25 WILLIAM BECKHAR	-	Please	State of M	aryland / D		of Health and	Mental Hy	_	9 7	1466
Physi	cian	Decedent's Neme (First, Middle, L.		Frankla	in Beckha	rdt	2. Dete of Des Month	th Day	Yeer	3. Time of Death
/Med Exam		4e. Fecility Name (If not institution, gi					MAY or Location of Death	4c. County		5:10P.M
Funera Directo				e (In yrs. last birtl 82 Y	hday) If Under 1 Months D		rs. 8. Date of Birth in. (Month, Da)	7, Year) 23,1915	9. Birthplece Country) Mary	e (Stete or Foreign Land
with the Maryland a or 28a-f show be notified at	tor	10a. State 10b. County Maryland N/A		10c. City, Town	or Location	Ва	ultimore (City		Inside City Limits
or 28	Director	10e. Street and Number			10f. Zip Co			10g. Citizen of \	Whet Country's	?
anu l	by Funeral	804 Rappolla Str. 11. Maritel Status 1 Never Married Married 3 Widowed 4 Divorcad	12. Wes Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		13. Wes Decedent If Yes, specify	21224 t of Hispenic Origin? Cuban, Mexican, Put	(Specify Yes or No- erto Rican, etc.)	United 14. Rac Blac Specify	e - American l ck, White, etc.	Indien,
	Completed	15. Decedent's E (Specify only highest gi		i+)		fone during most of w etired)	vorking	16b. Kind of B	usiness/Indust	try
Maryland 2 d 2 should be filled its and Mental Hygin 7 is marked other traumatic event, is	To Be Co	7 Years 17. Fether's Name (First, Middle, Les Simon Beckhards			<u>Crane Ope</u>	18. Mother's N	ame (First, Middle,		eel Inc	lustry
C - N -		19a. Informant's Name/Reletionship Wis. Catherine	(Type, Print) Wife		-	treet and Number or	Rural Route Numbe			21224
Baltimore, semit. Pages 1 a lopartment of Hea mortant: If Item my injury or othe my injury or othe		20a. Method of Disposition 1 ☐ Burlel 2 【☐ Cremation 3 [4 ☐ Donetion 5 ☐ Other (Special Contents)		20b. Place of cemetery	Disposition (Neme of cremetory or other	~ ~ ~	Dete	20c. Location -		
10311		21. Signeture of Funeral Service Lieu 23a. Part. Enter the disease, or con shock, or hear millure. List only	col		22. Neme end A Duda-Ru 1922 Wi	ddress of Fecility Ck Funeral se Ave. 1	2 Home of Dundalk. 1	Dundal	k, Inc.	
Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in deeth)		sclerot Due to (or as e co		iovascul	ar Dise	ase		ion one Doali
58760, icete be executed physician and s the buriel-transit	cai Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events	c	Due to (or es a co						
centification of the second of	Physician/Medic	resulting in deeth) Last	d	Due to (or as e co	insequenca or):				1	
P.O. hat the de by the deteched	by Physic	Pert II. Other significant conditions	contributing to death be	ut not resulting in	the underlying caus	e given In Pert I.		obacco uee co	ntributa to the	cause of death?
Record law require hes been sige 2 should	Completed b						24a. Was a perfor	ction	avallet comple of dea	
- + 50	Be Co	25. Was case referred to medical				26. Place of D	eath (Check only or	es XIXNo	1 ∐ Ye	es 2 No
of Vita Physician: ribis certific oral director,	To	axaminer? 1 XYes 2 □ No	Hospital: 1 Inpatie	nt 2 ER/Out	patient 3 DOA	Other:	Home 5 XResid		er (Specify)	
Sion tending leath. tor: After the fune	ertification:	27. Manner of Death 1 □XNaturai 5 □ Pending 2 □ Accident investigatio 3 □ Sulcide 6 □ Could not be		y Year) 28b. Ti	me of ury M	Injury et Work? 1 Yes 2 No	28d. Describe h			
Division Attention 24 hours efter deat Funeral Director: etely filled in by the	O	3 Sulcide 6 Could not be determined		ury - At home, fam :. (Specify)	n, street, factory, of	fica	28f. Location (S. City or Town	treet end Numb n, Stete)	er or Rural Ro	ute Number,
Hospital 24 hours Funeral letely filled	dicai	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exam	nysician: To the best of minar: On the basis of end manner sta	examination end/	death occurred at the for investigation, in a	ne time, date end place my opinion, death occ	ce, and due to the courred at the time, d	ause(s) end ma late and place,	inner as stated and due to the	d. cause(s)

Dixon M.D. Hay 1 4 1997

111 Penn Street, Baltimore, Maryland 21201

30. Name and andress of pason who completed cause of death (Item 23e) (Type, Print)

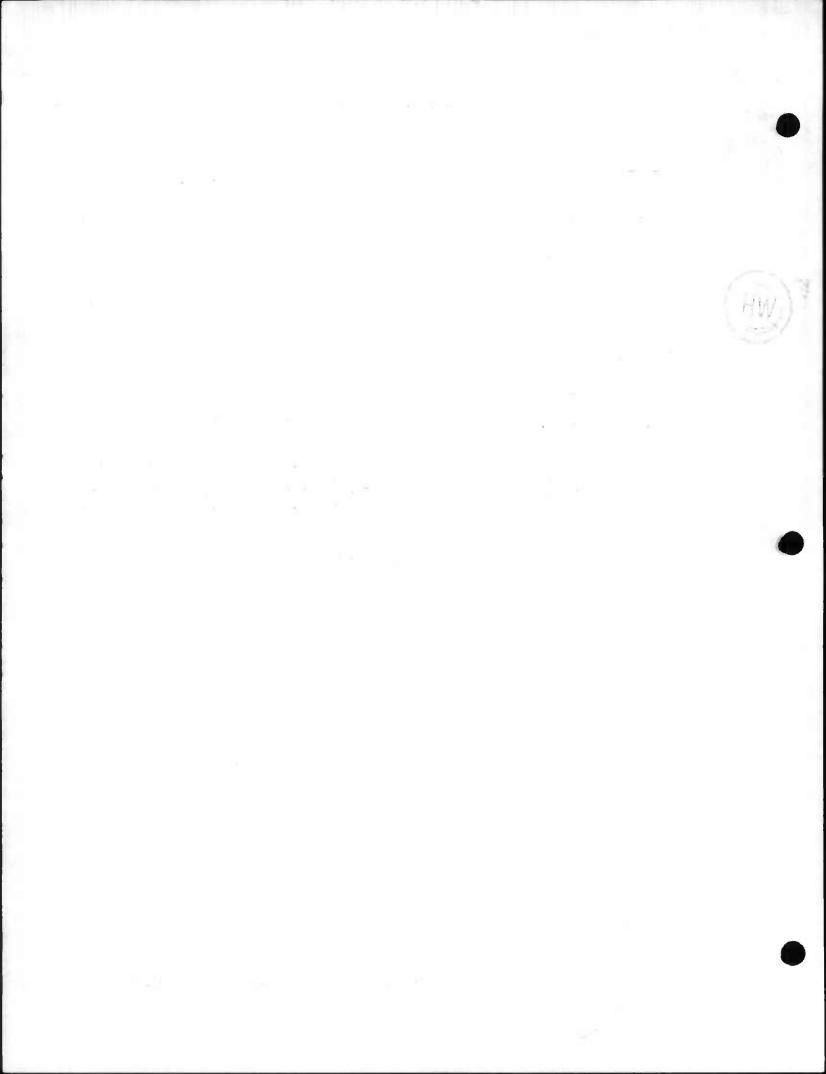
29c. License number

O.C.M.E.

29d. Date eigned (Month, Dey, Year)

MAY 10,1997

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Neme (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 12:55 PHYLLIS 1997 BECKETT MAN /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner LEVINDALE NURSING BALTIMORE N/A CENTER if Under 1 Year if Under 24 Hrs. | Months Davs Hours Min. 5. Sociei Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth Jumonth, Day, Year) Jumonth, Day, Year) 9. Birthplaca (Stata or Foreign **Funeral** 125 18 9042 Months PENNSYLVANIA Director Usuei Residence of Dacedant 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yea 2 No MD. N/A BALTIMORE Director 2 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 8 5238 DENMORE AVENUE 21215 U.S. OF A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 2 No If Yas, Giva Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indian. 1 Never Married 2 Married 1 ☐ Yas 2 No altimore, Maryland 21215-0020 Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) N/A (1-4or 5+) CAFETERIA SUPERVISOR A.R.A. SOC. SEC. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Pages 1 and 2 should be MAZIE WHITE AARON WILLIAMS 19e. Informent'a Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5238 DENMORE AVE. BALTO., MD. 21215 Department of Health reportant: If Nem 27 HENRY DIGGS (BROTHER) 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stata BALTO 20e. Method of Disposition Dete 1 Burlel 2 Cremetion 3 Ramoval from Stete 4 Donation 5 Other (Specify) ST. LUKES CEMETERY 5/16/97 REISTERSTOWN, MD.CO. 21. Signeture of Toparal Sarvice Licanses LEWIS GWYNN2. Neme and Address of Fecility LEWIS T. GWYNN FUNERAL HOME 21215-6393 23a. Pert1. Enter the disease, or complications the deeth. Do not antar the mode of dying, such as cardlec or respiratory errast, shock, or heert failure. List only one ceuse — ech line. ,MD Approximata triterval Between Onset and Deeth **Physician** /Medical tmmediete Cause (Finel ASPIRATION disaase or condition resulting In deeth) **Examiner** Examiner Cerebrovas physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) use as ed by the a detached f Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findinga evellable prior to completion of cause of deeth? Completed 24e. Wes an autopsy performed? peed has 1 Yes 2 No 1 🗆 Yes 2 DAG certificate 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas Za No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? Certification: After 1 BNetural 5 Pending Investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al 1 Yes 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29e. Certifler Medicai completaly (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number eted cause of death (Item 23e) (Type, Print) DEBRAS WERTHEINER 2434 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature

chia Davidson

Registrar

State



K.

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description the state weeks the breaks in

State of Maryland / Department of Health and Mental Hygiene

14671

							Cer	tificate	of L	Death		Reg. No	i.	1	14011
DI 1.	1. Dece	dent's Name (First, M	iddle, Lest)			_				2. Data of De				3. Tima of Deeth
Physician /Medical	RO	OBIN	STA	NLEY		CULP	EPP	ER			Month MAY	2.	y 1997	Year 7	9:22pi
Examiner	4a. Fecil	ity Name (If not institu							4t	. City, Town, or L	-	-	. County o		J. 22 P.
	GRI	EATER BA	LTIM	ORE M	EDIC	AL C	ENT	ER		TOWSON		B	A T.TT 7	MORE	
Funeral		Sacurity Number	6. Se:	x	_	yrs. lest bi		If Under 1 Y		If Under 24 Hrs.	8. Dete of Bi	rth		9. Birthplac	a (Stete or Foreig
Director		-58-8760 esidenca of Decedent]M 2 ∏ _F	4	15	Yrs.	Months D	eys	Hours Min.	NOV.	,195	1	Mary 1	and
	Mary	rland Anne		del	100	Gle		rnie						10d	. Inside City Limit:
al Director		et end Number Hollywood	Ct.		,			10f. Zip Co. 210					izen of W	het Country	?
should be filed within 72 hours after earth and Mental Hyginism marked other than "naturel; or increase armstic event, the Medical Examinant To Be Completed by Funeral	1 0 1	ei Stetus Never Married 2014 Widowed 4 Divord	Married	12. Wes Dec Armed F 1 Tes If Yes, G Yeer or I	orces? 2 X No ive	in U,S.	If	Vas Decedent Yes, specify	Cuben	panic Origin? (Sp., Maxican, Puarto Specify:	pecify Yes or No Rican, etc.))-		- American k, White, etc	
permit. Tages I and Should be lied with 7 L hours an Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or eny injury or other traumatic event, the Medical Examples. To Be Completed by F	Eleme	15. Dece (Specify only hig ntery/Secondary (0-1)		e completed) College () (1-4or 5+)	16e			ccupe one di etired)	tion uring most of work	king	Fe	edera	siness/indus	reau
event, the	17. Fethe	er's Neme (First, Midd		2				Clerk		18. Mother's Nem		, Me <i>lde</i> n			icion
is marked raumatic	19e. Info	orment's Neme/Reletto	onship (Ty		CINKO	190	o, Meilin	g Address (St	reet e	nd Number or Ru	ral Route Numb	er, City o	or Town, S		ode)
ment of Health and if them 27 is ury or other train	20e. Met	y G. Culpo hod of Disposition Burlel 2 ☐ Cremetic			20	0b. Plece o	f Dispos	ition (Neme o	of		Dete	20c. Lo	ocation - C	21060 City or Town	
Department of important: If eny injury or once.		Donation 5 ☐ Other ature of Funeral Servi			G	arden				of Facility Tunera				e Co.	, Ma.
89 E 2 8	1	Luch	1	1-30	Sol	< ·				astern A				M 21	221
	23g Pa	tt. Enter the disease.	or compli	cations that	asused the	deeth. Do							ex, r		pproximete
hysician	sho	tt. Enter the disease ock, or heart failure. I	ist only or	M CHIMB DIT	each line.				,					in	terval Between nset end Death
Medical	Immedie	te Cause (Finel		00	-coin	ATTA	h	EA	, , ,	1				1	. 2101
kaminer	resulting	or condition in deeth)	е	100	7/110	1101	/	11/10		MPHON					WEEK
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ansit I		T-44 81 4 414	C b	N					67	rina	74			i	3 12
ia Hra	if eny, le	ielly list conditions, eding to immediate			Due	to (or es e	consequ	ience of):							
use as the buriel-transit	Ceuse (I thet initia resulting	Inter Underlying Disease or Injury Ited events In deeth) Lest	1		Due t	to (or as e	consequ	ence of):							
d by the attending letached for use as Physician/Me	Pert II. Of	ther significant cond	itions con	tributing to d	leath but not	resulting i	n the un	derlying cause	e giver	n in Pert I.	23b. Did	tobacco	use cont	tribute to th	e cause of death
detac detac											1 🗆	Yes 2	SCHO :	3 Probat	dy 4 🗆 Unknow
been sign should be leted by											24e. Wes	en eutor	osy	avalla	autopsy findings ble prior to letion of cause
ata has been signed by the atterpaga 2 should be detached for Completed by Physicial											1 🗆	Vac al	2000	of dec	
	25. Was	case refarred to medi	cal							00 Diag : 1 D			COIO	1 🗆 Y	as 2 No
	exam	iner?		ospitel:	Inpatiant	2□ ED/C	ineti	a 🗆 🗆	Other	28. Piece of Deel			0 [70	10	
E	27. Mann	er of Deeth		28e. Date	of Injury	2 ☐ ER/Ou 28b.	itpatient Time of	3LI DOA	injury :	4 LI Nursing no	ome 5 ☐ Resi 28d. Describe				
or death. Sctor: After by the funer ification:		leturel 5 Pen Accident inve	ding stigetion	(Mon	ith, Dey Yea		njury			es 2 No					
is after death. al Director: After t led in by the funera Certification:	3□ 5	Suicide 6 ☐ Cou	ld not be irmined	28e. Place build	a of Injury - / ing, etc. (Sp	At home, fe ecify)	rm, stre	et, fectory, off			28f. Location (City or To	Street en wn, Stete	d Number	r or Rural R	oute Number,
within 24 hours after To the Funeral Dir completaly filled in Medical Cert	29e. Cerl (Che		ying Phys ai Examin	er. On the b	best of my asis of exeminer stated.	knowledge Inetion en	, deeth d/or inve	occurred et the	e time	, dete end plece, nion, deeth occur	end due to the red et the time,	ceusa(s) dete end	end men plece, ar	ner es stete nd due to th	ed. e ceuse(s)
To the comp	29b. Sign	eture end title of certi	fier					29c. Lic	ansa i	27730		29d. Det	te signed	(Month, De	y, Year)
17	30 Nome	and address of name	on who ac-	unleted servi	no of do-th	ltom 00-1	There is	rint)					- /		
10	6	GT- end eddress of person Ayy T-	Can	I M Caus	つり つり	650	S S	N. C	40	uies s	7 - 1	Stri	The	P 2	1204

State Registrar

State of Maryland / Department of Health and Mental Hygiene

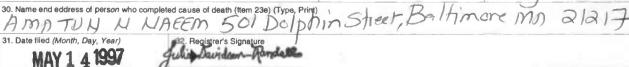
					Certificate	of Death		Reg. No.	31	14012
Dhuaia	ia	1. Decedent's Name (First, Middle, L	ast)				2. Dete of D		Year	3. Time = D==th
Physic /Med		Harold		COOK				13, 1997		9:30 mm
Exami		4e. Fecility Neme (If not institution, g	ive street end numbe	er)		4b. City, Town, or	Location of Dec	9th 4c. County	of Death	
		Franklin Squar				Roseda1	-		1timo	ore
Funeral			Sex 7. / 10XM 2□ F	Age (In yrs. lest	Months D	feer if Under 24 Hrs ays Hours Min	. (Month, L	Birth De <i>y, Year)</i>	9. Birth	place (State or Foreign ntry)
Director		225–24–2335 Usual Residence of Decedent		77	Yrs.		July 1	12,1919		rinia
he Maryian 28a-f show notified at	ctor	Maryland Baltimon	re		own or Location					10d. Inside City Limits 1 ☐ Yes 2€ No
	ai Director	10e. Street end Number 901 Arncliffe Ro	oad		10f. Zip Co	de 1221		10g. Citizen of U.S		ntry?
WHE	Funerai	11. Marital Stetus	12. Wes Deceder Armed Forces	nt Ever in U,S.	13. Was Decedent	of Hispenic Origin? (Cuban, Mexican, Pue	Specify Yes or N	No- 14. Rec		can Indian,
8	by	1 ☐ Never Merried 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorcad	1 Yes 2 If Tes, Give] No	1 ☐ Yes 2 ဩ		nto Hican, etc.)	Specif	ick, White, y: Wh	ite
15-0 72 ho 72 ho	Completed	15. Decedent's I (Specify only highest g	Education rade completed)	1	6e. Decedent's Usual O	ccupation lone during most of wo etired)	orking	16b. Kind of B	usiness/in	dustry
212 I within	DE L	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Mechan			Ch-	-7 25	: 11
D D D T T		17. Fether's Name (First, Middle, Las	(t)		Mechan		me (First Midd	le, Meiden Sumer	el Mi	LIT
Maryland 12 should be file h and Mental Hy lis marked oths frieumatic event,	To Be	Anbers Bert Cool	*				Widene		,,,,	
E 45 25 L		19a. Informant's Name/Relationship Ruth E. Cook (V	(Type, Pnint)		19b. Mailing Address (S 901 Arncli		Essex,		Stete, Zip 221	Code)
IOre, ges 1 a If Hem or othe		20e. Method of Disposition		com	a of Disposition (Neme a stery, cremetory or other	of r pleca)	Dete	20c. Location	- City or To	own, State
Pages nent of ant: If its		1 ★Burlal 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spec		6	Hill Mem.G		6/1997	Baltimo	re, (Co. Md.
Baltimore, permit. Pages 1 a Department of Hea Important: If Hem. any Injury or othe		21. Signature of Furnital Service Lion	onsee	1		ddress of Facility nski Funer d Eastern			Би	21221
		234 Part LEnter the disease, or con	nplications that caus	ed the death. I					MCL.	21221 Approximate Intervel Between
Physician		The stribute cast you	y One 00036 Gil 66011	iii to.					1	Onset and Death
/Medical Examiner		Immediate Ceuse (Final disease or condition	Pneum	onia						3 Months
Examilier	L.	resulting In death)	α.	Due to (or es	e consequenca of):				1	3 110110115
De isi	nine	_	b							
\$8760, icata be executed physician end s the buriel-transit	Examiner	Sequentielly list conditions, if any, leading to immediate		Due to (or es	a consequence of):					
68760, ficata be ex physician ss the burie		cause. Enter Underlying Cause (Disease or Injury that initiated events	C	Due to for an	2 2222221222 of);					
5 5 6	Medical	resulting in deeth) Last		Due to (or as	e consequence of):					
Box eath cert ettendin for usa			d						1	
D. E	Physician	Part II. Other significant conditions	contributing to death	but not resultin	g in the underlying caus	e given in Pert I.	23b. Die	d tobacco use co	ontribute t	o the cause of death
res that the designed by the detached		Emphycema					15	Yes 2 No	3 Pro	bably 4 Unknow
Signe bed	b	Emphysema							0.05 14	
Records, he law requires the has been signe	etec	Coronary Artery	Disease					as en eutopsy rformed?	ev	Vere eutopsy findings vailable prior to completion of cause
I Records, P.O. The law requires that tha ste has been signed by the paga 2 should be detached.	Completed									death?
								Yes 21 No	10	☐ Yes 2☐ No
Of Vita Physician: this certific ral director,	Be C	25. Wes case referred to medical examiner?	Hospital:			Othor:	eth (Check only			
of Vital Physician: Tribis certificateral director, pa	- To	1 ☐ Yes 2 ☑ No 27. Manner of Deeth	1 X Inpa		Outpetient 3 DOA b. Time of 28c.	4 LI Nursing	1	sidence 6 Ott		(y)
VISION O Attending Ph or deeth. ector: Aftar th by the funeral	atlon	1 ☑ Netural 5 ☐ Pending Investigation		ley Year)	Injury M	Injury et Work? 1 Yes 2 No		,,		- 3-1
Division or Attending eleter deeth. Director: Aftar d in by the fune	Certification:	3 Suicide 6 Could not determined	286. Pieca of II	njury - At home etc. <i>(Specify)</i>	, ferm, street, fectory, of	fice		(Street end Numi own, Stete)	ber or Run	al Route Number,
Divisio To the Hospital or Attendit within 24 hours effer deeth. To the Funeral Director: A completely filled in by the to	edical C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the bes miner: On the basis and menner s	of examination	dge, deeth occurred et ti and/or investigation, in	ne time, date and plec my opinion, death occ	e, end due to the	e ceuse(s) end m e, date end placa,	enner as s	iteted. o the cause(s)
vithin Fo the	Me	29b. Signeture and title of certifier			29c. Li	cense number		29d. Date signe	ed (Month,	Dey, Year)
[]		1	0,,	111	w	D36663		May	13,	1997
10X		30. Name and address of person who	completed cause of	deeth (Item 23						
10		Stuart Willes M			in Square I	Orive.	Baltimo	re, Mary	land	21237
Sta	ite	31. Date filed (Month, Day, Year)		trer's Signeture				,		
Regist	ar	MAY 1	1997	Julia Da	vidson-Randese		<u> </u>			
	_		_	U						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 1997 MAY 10:40 pm HELEN CROSBY /Medical Μ. 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner GREENSPRING NURSING AND REHAB CENTER BALTIMORE CITY If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, OCT 12 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2CXF Months Deys MARYLAND Yrs. 93 Director 220-14-7708 Usuel Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits XXYes 2 No Director MARYLAND N/A BALTIMORE CITY 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code must be n U.S.A. 3409 W. NORTHERN PARKWAY Funerai 21215 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes → No
If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Race - American Indian, Bleck. Whita, etc. 1 Never Married 2 Merried 1 Yes XX No Specify: Specify: BLACK þ XX Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) PRIVATE 11th grade HOUSEKEEPER med v Baltimore, Maryland 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) Peges 1 and 2 should be the ment of Health end Mental Heart; if item 27 is marked oth lury or other traumatic event Be HARVEY ROSE **EUNICE ROSE** 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 W. Northern Parkway, Baltimore, MARYLAND 21215 Iva C. Wilson/Neice 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or Cedar Hill Cemetery 5 - 13BROOKLYN, MARYLAND 21. Signeture of Funeral Service Linenses 22. Name end Address of Facility WILLIAM C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medicai tmmediete Cause (Finet diseese or condition resulting in death) 10965 Examiner Examiner ears The law requires that the death certificate be executed buriel-transi Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Box 68760, Physician/Medicai the Due to (or es e consequence of): for use Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was en eutopsy certificate has 1 ☐ Yes 2 No 1□ Yes 20 No Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Hospitat 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describé how injury occurred After 5 Pending investigation 1 Natural efter death. 2 Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ò To the Hospital of within 24 hours of To the Funeral D 12 Certifying Phyalcian: To the best of my knowledge, death occurred et the time, dete and plece, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier Medicai completely (Check only one) 29d. Date signed (Month, Day, Year) H Wason MD 15503

State Registrar

31. Date filed (Month, Day, Year)





1. DECEDENT'S NAME (FIRST, LELLIET	Middle, Lest) B.	CARLO	ss					2. DAT	E OF DEATH	7 199	YEAR 7	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER	ER	5. SEX	6. AGE (In y	rs. last birthday)	IF UNDER	DAYS	IF UNDER 24 HI	(0.4-	E OF BIRTH oth, Day, Year)	ELA!	6. BIRTH	PLACE (State or Foreign
410-30-0351		t 🔀 M 2 🗆 F	71	YRS.	MONTHS	DAYS	HOURS M	SE	PT 09,	1925		NESSEE
9a. FACILITY NAME (If not ins				0.83	9b. CITY	, TOWN	R LOCATION O	F DEATH		9c. COU	NTY OF O	EATH
CATON MANOR	NURSI	NG HOME			BA	LTIM	ORE				N/	A
RESIDENCE OF DEC												
10a. STATE	10b. COUNT			10c. CI1	TY, TOWN O	OR LOCAT	ION					10d. INSIDE CITY LIMITS?
MD		N/A				BALI	IMORE					1X YES 2 NO
10a. STREET AND NUMBER						101	. ZIP CODE			10g. CITI	IZEN OF W	HAT COUNTRY?
3373 ST. BEN	NEDICT	STREET					21229				U.S	.A.
11. MARITAL STATUS 1 Never Merried 2 8 3 Widowed 4 Divor		12. WAS DECEDED FORCES? IF YES, GIVE	X YES	2 NO S	1.75	If yes, sp	ecify Cuban, Ma 2 NO S			es or No—	14. RACE Black Specif	- American Indian, , White, atc.
	EDENT'S EDU			a. DECEDENT'S				10	Sb. KIND OF BU	JSINESS/INC	DUSTRY	
(Specify only Elementary/Secondary (0-	highest grade	College (1-4 or 5	4)	(Give kind of Itle. Do NOT u	work done use retired.)	during mo	st of working					
10TH GRADE	12)	College (1-4 or 5	"	MECHA	NIC				AUTOMOI	BILE	REPA	TR
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LAR'S SIGNATURE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to fill filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year)
MAY 1 4

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-16 Rev 1/89

200 St. 11 Lat. 12

NAME AND YOU

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4675 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death 3. Time of Death Month Bertha Chmielewski 9 1997 May 12:30pm 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Heritage Nursing Home Dundalk Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthpleca (State or Foreign Country) Months Deys 1 ☐ M 2 💢 F Yrs. 212-01-2602 85 Nov.25,1911 Maryland Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Md. Baltimore N☐ Yes 2☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 611 South Old Ham St. 21224 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Yes, Give 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ₩idowed 4 Divorced Yeer or Detes: 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6 yrs. Cleaning Hotel 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Adam Bujnowski Monica Waszkiewicz 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Bernard Chmielewski 7236 Conley St. Baltimore Md. 21224 20b. Plece of Disposition (Neme of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Holy Rosary 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete 5-13 Dundalk 4 ☐ Donation 5 ☐ Other (Specify) re of Fustificat 22. Name end Address of Fecility Connelly Funeral Home Of Dundalk 23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Coronary Artery Disease immediete Ceuse (Final 12 years diseese or condition resulting in death) Due to (or es e consequenca of): Essential Hypertension 18 years Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of) Hypercholesterolemia 15 years Due to (or es e consequence of): Chronic Obstructive Pulmonary Disease 10 years Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Diabetes Mellitus Type II 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes an eutopsy 1 ☐ Yes 2 ☐ No

Physician/Medical Examiner The lew requires that the death certificate be executed ician and buriel-trans physician s the burie

Physician

/Medical

Examiner

Director

Funeral

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Baltimore, Maryland 21215-00

Box 68760,

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Division of Vital

Physician:

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Pages 1 and 2 should be nent of Health and Mental

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Department of Health a important: If Item 27 is any injury or other tra once.

Physician

Examiner

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page 2 should

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Be Completed

Certification: To

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25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

29c. License number

3 Sulcide 6 Could not be determined 4 Homicide

28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner as steted.

2 Medicat Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and penner stated.

29b. Sha

(Attending Physician) D14160 29d. Date signed (Month, Dey, Year) 05/12/97

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

State Registrar

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31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signeture relia Davidson

Fred VV

Water Special YAM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item15 5-14-97 FilmG747 W.H.Per F/H 14676 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2 Date of Death **Physician** MAYMonth NELLIE RUSHTON DUNLAP 5:30 P.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner TOWSON, MARYLAND BALTIMORE
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplac SAINT JOSEPH MEDICAL CENTER 5. Sociel Security Number 7. Age (In yrs. last birthdey) 6. Sax **Funeral** 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) 1□ M 2□ F Months Deys Hours Min 91 Yrs. Director 213 74 5830 ENGLAND May 22,1906 with the Marylend 10a State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show tre Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MARYLAND BALTIMORE COCKEYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 10312 Malcolm Circle 21030 USA Apt. D 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No
If Yes, Give Yeer or Detes: 11. Merital Status 13. Wes Decedent of Hispenic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Deperment of Health and Mental Hygiene. Important: if itsm 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Examinations." 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à Specify: 3 Widowed 4 □ Divorced WHITE Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11/2 N/A 12 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Authur Chester Rushton Clara Cooper 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 5 Jonco Court, Cockeysville, MD 21030 Vernon Bruce Dunlap/ Son 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 15 May Parkwood Cemeterv 1997 Parkville, MD 21. Signature of Funeral Service Liver 22. Neme end Address of Fecility Lemmon Funeral Home of Dulaney Valley, Inc. 23a. Per . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediete Cause (Finel diseese or condition resulting in death) LESS OTHAN /Medical ASPIRATION PNEUMONIA **Examiner** Due to (or es e consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest pug Due to (or es e consequence of): physician s the buriel P.O. Box 68760. Physician/Medical Due to (or es e consequence of): attending p 88 ed by the a Pert It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE Records, þ cata hes been significant page 2 should b 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Be Completed 24e. Wes en eutopsy performed? ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE certificata 1 Yes 2 (X) No 1 ☐ Yes 2√ No Division of Vital Hospital or Attending Physician: 24 hours efter death. 25. Was cese referred to medical exeminer? director, 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this Director: After this in by the funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred After 1 Neturel 2 Accident 5 Pending Investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours efter To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) end menner stated. 29a, Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D16492 30. Name end address of person who completed cause of seeth (Item 23e) (Typa, Print) BEATRIZ P. DIZON, 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar 31. Dete filed (Month, Day, Year) MAY 1

M.D., 32 Registrer's Signeture a Davidson

28 p 1 AV

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: 1 per DR. G-747 5-13-97 eoh 1. Decedant's Nama (First, Middla, Last) 2. Data of Death ANN LEE DELTRICH Month 2 PM 10 1997 4c. County of Death MAY 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death CHARLESTOWN CARE CENTER CATONSVILLE BALTIMORE 7. Age (In yrs. last birthday) | If Undar 1 Yaar | if Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foreign Country) 1□M 2₺F Deys 90 Yrs. 217-16-5531 MARCH 25,1907 MARYLAND Usuai Rasidanca of Dacadant 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? 707 MAIDEN CHOICE LANE - 8T06 21228 U.S.A. 12. Was Decedent Ever In U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxicen, Puarto Ricen, atc.) 14. Raca - Amaricen Indian, Bleck, Whita, etc. 1 ☐ Yes 2 ☐ No If Yas, Giva Year or Detas: 1 □ Navar Married 2 N Marriad 1 ☐ Yes 2 ☐XNo Spacify: Specify: 3 ☐ Widowad 4 ☐ Divorced WHITE 15. Decedant's Education (Spacify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Collaga (1-4or 5+) YR CLERICAL SOCIAL SECURITY ADM 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) FRANKLIN E. DeVEAS MAGGIE F. KERCHNER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) 707 MAIDEN CHOICE LANE-8T06-CATONSVILLE, MD 21228 LAUREN R. DEITRICH(HUSBAND) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cramation 3 □ Ramoval from Stata LOUDON PARK CEMETERY 5/14/97 BALTIMORE 4 ☐ Donation 5 ☐ Qthar (Specify) 21. Signature of Euneral Service Licensee 22 Nama end Addrass of Fecility HUBBARD FUNERAL HOME INC. 11 21229 4107 WILKENS AVENUE-BALTIMORE, MD 23a. Part. Entar the disaasa, or complications that ceusad the death. Do not antar tha moda of dying, such es cardiac or respiretory errest, shock, or haart failura. List only one cause on each line. Approximete Intarval Batwaan Immediata Causa (Final disaasa or condition rasulting in daath) 3 WEEKS & METASTATIC DANCER TO THE BRAIN - PRIMARY NOT DETERMINED Dua to (or as a consaquance of): Dua to (or as a consequance of): Dua to (or es e consequance of): 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 20 No

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stata

MD

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Funeral

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Department of Important: If any injury or

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21215-0

Baltimore, Maryland

Box 68760.

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Records,

Division of Vital

Examiner

or Attending Physician: The law requires that the death certificate be executed burial-transit the for use certificate this After efter deeth. | Director: Aff in by Hospital

Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last Physician/Medical Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. Completed by CANCIER OF 25. Was casa rafarrad to medicel axaminar?
1 ☐ Yas 2 ☑ No 26. Placa of Daath (Chack only ona) Be Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicida • Funeral Di 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cartifian To the Hosp within 24 hou To the Fune completely fi Medical 29b. Signetyre end titia of certifier 29d. Data signed (Month, Day, Year) 29c. License number

State Registrar

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30. Name and address of person who completed ceuse of death (Itam 23a) (Type, Print) DAMEYON E FREDERICK ROAD, SUITE 18 BALTIMORE, 32. Registrar's Signatura

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May 1 & 1997 A State of the sta

A.860 L.Ball

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State Registrar 31. Date filed (Month, Day, Year) MAY 1 4 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene

14679

Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:15 PM .Tames R. Evick May 1997 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ivy Hall Geriatric Center Middle River Baltimore # Under 1 Year | Months Days H Under 24 Hrs. 8. Data of Birth
(Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F 234-42-9530 Yrs. Director 67 Feb. 27, 1930 West Virginia Usuai Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 920 Homberg Avenue 21221 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 XYes 2 No If Yes, Give WW II Year or Dates: WW II 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Sales Uniform Company Department of Health and Mental Pages 1 and 2 should be files, important if them 27 is or any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Cletus Evick Florence Hoover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Reid Douglas Evick 7807 Philadelphia Rd. Baltimore, Md. 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 5/12/1997 Baltimore, Co. Md. 4 ☐ Donation 5 ☐ Othar (Specify) ^{22. Name and Addrass of Facility} Bruzdzinski Funeral Home P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, splock, or heer feilure. List only one ceusa on each line. 1407 Old Eastern Avenue Essex, Md. 21221 Approximate Interval Between Onset and Death **Physician** METASTATIL WASOPHARTHGEAL CARCINOMA /Medical immediate Ceuse (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner physician and the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Undarlying Cause (Disease or Injury that initiated avents resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of): USB P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed peen 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending

Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

(Check only one) 29b. Signatura and titla of certifier

3 Suicide

29a. Certifier

29d. Date signed (Month, Day, Year)

San ader a Falle M.D

Investigation

1 ☐ Yes 2 ☐ No

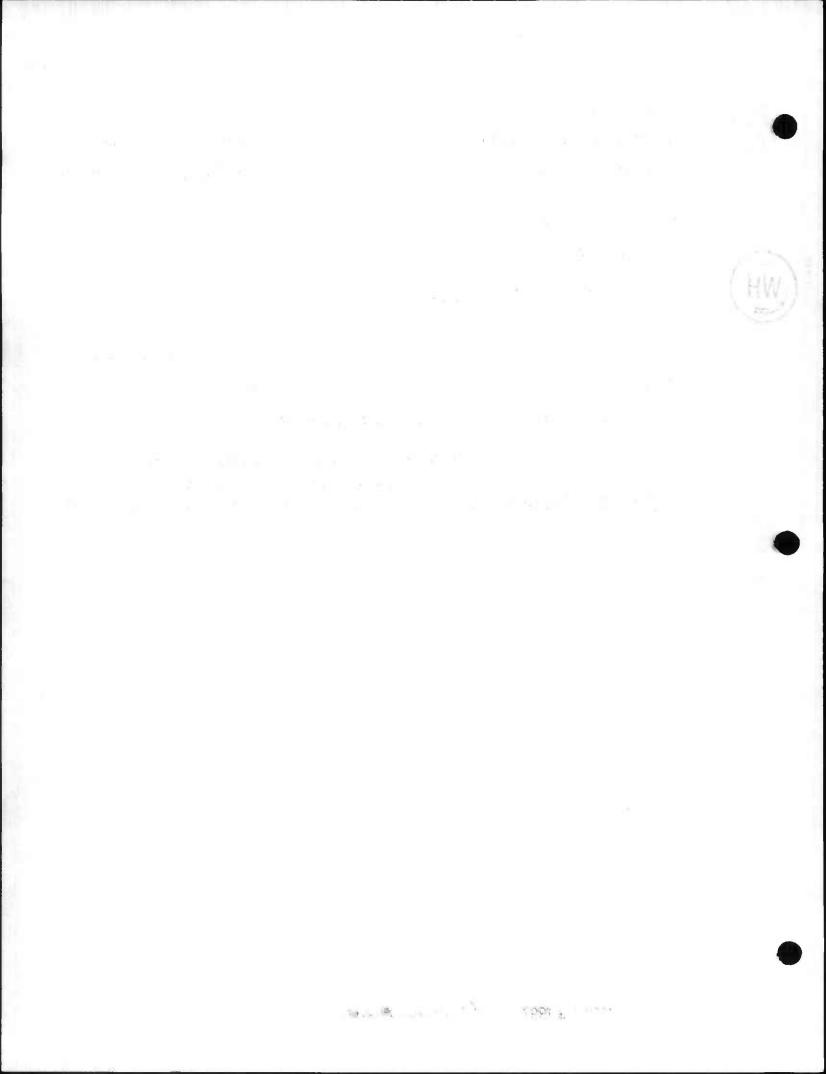
May 9, 1997

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Pri SAVIMDER IL TULKA 32. Registra's Signeture

Saltimere MD

Registrar

Medical



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Day **Physician** ma Mar 997 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ST. ELIZABETH'S HOME BALTIMORE N/A | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Min. | MRCH 18,1922 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** 1 M 2 J.F MARYLAND 215-16-1969 Yrs Director 75 Usuel Residence of Decedent 10e Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No by Funeral Director MD N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 713 DORCHESTER ROAD 21229 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2X No if Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ XNo Specify 21215-002 Specify. 3 ☐ Widowed 4 ☐ Divorced the Medical Ex WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry 72 (Specify only highest grade completed) Hygiene. Pages 1 and 2 should be filed within Elementery/Secondery (0-12) College (1-4or 5+) 2 YRS HOMEMAKER HOMEMAKING Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 89 marked of JOHN MILES ANNA LABONTE la m 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If Item 27 is or other tha 713 DORCHESTER ROAD - BALTIMORE, MD 21229 CHARLES H. FURST, III (HUSBAND) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Depertment of Important: If any injury or once. 5/14/97 DRUID RIDGE CEMETERY PIKESVILLE, MD 21. Signeture of Fundam Servica Licensee 22. Neme end Address of Fecility HUBBARD FUNERAL HOME INC. 21229 4107 WILKENS AVENUE-BALTIMORE, MD 23a. Pert 1. Enter the disease, or complications that caused the down. Do not unter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final 6 months ancreo diseese or condition resulting in deeth) Examiner Due to (or es e consequenca of): Examiner Hospital or Attending Physician: The law requires that the death certificate be axecuted 24 hours after death. Funeral Director: Attar this certificete has been signed by the attending physician end Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of): P.O. Box 68760, eta has been signed by the attending physician paga 2 should be datached for usa as the buria Physician/Medical Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ Completed 24b. Were eutopsy findings evelleble prior to 24a. Wes en eutopsy performed? completion of cause of deeth? 2 000 1 ☐ Yes 2 ☐ No funeral director, 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 210 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No by the 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide To the Hospital of within 24 hours a To the Funeral Completally filled in the Completally filled in the completal of the comp 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner stated. Medical 29a. Certifier

29c. License number

29d. Dete signed (Month, Day, Year)

State Registrar

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29b. Signeture end title of certifier

30. Name end eddress of perso

31. Dete filed (Month, Day, Year)

1 4 1997

MD

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2 Registrar's Signeture

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 1997 Month **Physician** Mildred H. Forney May 11, 10:30pm /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Heritage Nursing Home Dundalk Baltimore If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1□ M 21 F 85 Yrs. 214-22-9103 Aug. 24, 1911 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Dundalk 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2644 Yorkway 21222 USA Funeral 12. Wes Decedent Ever In U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Rece - American Indian, Bleck White, etc. 1 Yes 27 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 ☐ Yes ¾☐ No þ Specify: White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 yrs. Housewife Home 18. Mother's Neme (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be Milton Price Hattie M. Nordt 2 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Gloria A. Barnhart 35 Neptune Dr. Joppa Md. 21085 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Metro Crematory 5-12 Baltimore 5 ☐ Other (Specify) 4 Donation 22. Name end Address of Fecility Connelly Funeral Home Of Dundalk 23a. Pent Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one dause on each line. tmmediete Ceuse (Finet diseese or condition resulting in deeth) CONGESTIVE HEART FAILURE

Due to (or es a consequenca of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Physician/Medical Due to (or es e consequenca of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PNEUMONIA þ 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 28e. Dete of tnjury (Month, Dey Yeer) 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Neturet 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signeture and title of certifier 13664 30. Nime and eddress of person who completed cause of deeth (Item 23a) (Type, Print) 1576 MERRITT SLUD, BALTO, MO 21222 C. VENERACION JR MOPA

State Registrar

31. Dete filed (Month, Dey, Year) MAY 1 4 1997

33 Registrar's Signet

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Funeral

Director

Baltimore, Maryland 21215-0029

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Physician /Medical

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Hospital or Attending Physician:
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Box 68760,

Division of Vital Records, P.O.



State of Maryland / Department of Health and Mental Hygiene 9 7

14682

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State of Maryland / Department of Health and Mental Hygiene 97 14683

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	Examir		4e. Facility Neme (If not institution	give street and no	umber)			4	b. City, To	wn, or Lo	cation of Deet	h 4c. Count	ty of Death		· · · · · · ·	
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	pemit. Pages Department of I Important: If ite any injury or of		4 Donetion 5 Other (Specify) King Mem. Pk. Cem. 05-16-97 Randallstown, Mc													
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that the d	ed by the detached	Physician	Part II. Other significant condition	es contributing to d	leath but not rasu	alting in the u	nderlying cau	se give	en in Part i			tobacco usa co Yes 2□ No	3 Proi		4 Unknown	
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3 8	80 CA	mp.										/	of	daeth?	/	
											10	Yes 2 No	1[Yes	2 No	
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Physician	this or	P.	1 Yes 2 No		Inpatient 2			Othe	4 LI NU			dence 6 Ot		y)		
	h. After funer	lon	27. Manyfer of Death 1 ☑ Naturel 5 ☐ Panding		of Injury oth, Day Year)	28b. Time of Injury		Work			28d. Describe i	now injury occu	rred			
or Attending		Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homlcida determine	ot be 28e. Place	e of Injury - At holing, etc. (Specify	ma, farm, str	eet, factory, o		Yes 2□		28f. Location (S City or Tox	Street and Num vn, State)	ber or Rura	i Route	Number,	
To the Hospital	within 24 hours a To the Funeral D completely filled		29a. Cartifier 1 CertifyIng (Check only 2 Medical E	Physician: To the	a best of my know	viedge, death	occurred at	tha tim	a, date en	d plece, e	and due to tha	causa(s) end m	anner es s	teted.		
H ed	the Fu	fedical	- /	xaminer: On the b	nasis of exeminati iner steted.	IOLI WUCAOL IU				un occurre	ou et ine time,	uate and place	, and que to	ine cau	150(5)	
To	within To the comple	Σ	29b. Signature and little of dertifler		Shi	\cap	29c. L	icense C	number	108	4	29d. Dete sign	ed (Month,	Day, Ye	Br)	
	11	1	30. Name end address of personu	to completed call	e of death (Item	23a) (Type	Print) Dr.	. 6	arl	M3 14	ner!	1/	1	1	/	
	2, ,		15011	W. S	ava de	GA	SA	-	Ba	W	"TU	15,(12-	77	5	
	Sta	te	31. La Ved (Month Cory Par)	del: 35	Registrer's Sphat	1800	- 0		700			- /	-	-		

ANY 14 HOST CONTRACTOR

State of Maryland / Department of Health and Mental Hygiene

4684 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of D **Examiner** BALTIMORE CITY N/A THE JOHNS HOPKINS HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Dete of Birth (Month, Day, Year) November 6, 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Maryland **Funeral 3**€XM 2□ F Days 69 Yrs. 220-18-7762 Director Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Maryland Howard County Glenwood Director 1 Yes 2010 10e. Streei and Number 10f. Zip Code 10g. Citizen of What Country? Longwood Farm 21738 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Bleck, White, etc. 11. Maritai Status 1 ☐ Never Married 2 ☑ Married 1 XYes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ◯NNo p f Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry altimore, Maryland 2121 the Me Elementary/Secondery (0-12) College (1-4or 5+) attorney/horse breeder self employed 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be I next of Health and Mental I int: If them 27 is marked of Robert Henry Goldsmith Agnes Hardy Kemp 0 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Barbara Goldsmith/spouse Longwood Farm, Glenwood, Maryland 21738 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 8 Department of Important: If 5 ☐ Other (Specify) 4 Denetion St. Louis Cemetery 19 MAY 97 Clarksville, MD 21. Signature of Echeral Shrvice Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failura. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical mediete Causa (Final diseese or condition resulting in death) Examiner Examiner the bunal-transit Sequantially list conditions, if any, leading to Immediate causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in death) Lest pue Due to (or as a consequence Records, P.O. Box 68760 physician Sensi Physician/Medical Due to (or as a consequenca of): 88 ettanding | signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given In Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ should should 24a. Wes en eutopsy performed? 24b. Were autopsy findings available prior to complation of cause of daath? Completed certificata 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Was casa referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: 2 ANO Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas 1 Inpatient 2 ER/Outpatient 3 DOA this funerai 27. Menney of Daath 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 Natural 5 Pending Investigation is or Attending s after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify) 4 | Homicide To the Hospital or within 24 hours aff To the Funeral Di completely filled It Cartifying Physician: To tha best of my knowledga, daath occurred at the time, data and plece, and due to the causa(s) and mannar as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 32. Registrar's Signatura State whice Davidson

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 0.7

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					Ce	ertificate of	Death		Reg. No.	- 1	1400	J
Physic	an	Decedent's Name (First, Middla, Last	st)					2. Dete of De Month	eeth Dey	Yeer	3. Time of Dec	əth
/Medi		Anna	Mary		GAMB	INO			9, 1997		4:10 P	.1
Exami	ner	4a. Fecility Neme (If not institution, give	a street end number)			-	4b. City, Town, or	Location of Deal	th 4c. County	of Deeth		
		Franklin Square					Rosedal		Balt	imore		
Funeral Director		5. Social Security Number 6. S 066-07-4145	D	a (In yrs 34	last birthdey Yrs.	Months Deys			rth ey, Year) 9,1912	9. Birthp Cour New	place (Stete or Fontry) York	reig
B .		Usuel Residence of Decedent 10e. State 10b. County		10a Cit	y, Town or t	acation				1.		
h the Maryland r 28a-f show Lootified at	ctor	Maryland Baltimore	9	100. 011	Esse						1 ☐ Yes 2	
The or 28	al Director	10e. Street end Number 5 Brett Ct. Apt.	223			10f. Zip Code 2122	21		10g. Citizen of U.S.		ntry?	
Enmission of the Control of the Cont	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 図 N If Yes, Give Year or Detes:		S. 13.	. Was Decedent of if Yas, specify Cul	Hispenic Origin? (S ban, Mexican, Puer o Specify:	Specify Yas or Noto Rican, etc.)	0- 14. Ra Ble Specii	ce - Amaric ock, White, fy: Wi		
in 72 in 72 in matur	Completed	15. Decedent's Ed (Specify only highast gre	de completed)		18e. Deci (Giv life.	edant's Usual Occu e kind of work done DO NOT use retin	petion during most of wo	rking	16b. Kind of B	usiness/in	dustry	
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D High	BeC	17. Fether's Neme (First, Middle, Last)					18. Mother's Na	me (First, Middle	, Meiden Sumer	ne)		
arylan should be nd Mental marked o	To B	Joseph Vulpi					Mary C	irillo				
THE R. P. LEWIS CO., LANS.	_	19a. Informent's Neme/Reletionship (1					et end Number or Ri					Ω
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0 8523		20e. Method of Disposition 1		0	emetery, cre	cosition (Neme of emetory or other planetery		13/1997	Woodsid			
Baltim permit. Pag Department Important: any injury obce.		21. Signature of Funeral Service Liceo	1.	/	i	Name and Addr	ess of Eaclity Ki Funera	al Home	P.A.			
- 452 - 4		Jun Sei	agegens	a			Eastern A			Md. 2	1221	
		235. Pert1. Enter the disease, or company shock, or heart feilure. List only	plications that caused ona ceuse on eech lin	the death	h. Do not er	nter the mode of dy	ring, such es cardia	c or respiretory a	arrast,		Approximeta Intervel Between	n
Physician											Onset end Deet	h
/Medical Examiner	l.	tmmediete Ceuse (Finel diseese or condition resulting in death)	e. Cardiop	ulmo	nary	Arrest					5 Minut	es
	ē			Due to (o	res a conse	equence of):						
pet list	를		0.			cular Con	npromise					
\$8760, icate be executed physicien and the buriel-transit	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury			r es e conse							
68760, ificate be exe g physicien a as the buriel-		Ceuse (Diseese or injury thet initiated events	U				Ischemia					
rtificate ng phy	Medical	resulting in death) Last	,	Due to (or	r es e conse	iquence or):						
Box eath cert			d							-		
Geath death	icla	Part ii. Other eignificant conditions co	ntributing to death bu	it not resi	ulting in the	underlying cause o	iven in Pert I	23h Did	tohacco use co	ontribute t	o the cause of de	aath
P.O. that the detached detached	/ Physician/		The day of the document of		31419 11 110	aridonying oddao g	or arrest.				bably 4 ☐ Unk	
Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the ettending physician and in by the funeral director, page 2 should be detached for use as the buriel-transit	Completed by							24e. Wes	s an eutopsy ormed?	ev	ere eutopsy findir eileble prior to empletion of cause deeth?	
The I	Con							10	Yes 2X No	1[☐Yes 2☐No	
of Vital I	Be	25. Was case referred to medical exeminer?						ath (Check only	one)			
hysic centis ce	10	1 ☐ Yas 2 🕅 No	Hospital: 1X Inpatie	nt 2 🗆	ER/Outpatie	ent 3 DOA	ther: 4 Nursing I	loma 5□Res	idence 6 □Otl	ner (Specii	(y)	
Vision o' Attending Phirideath. Frideath. Sector: After thi by the funeral		27. Menner of Deeth 1 Neturel 5 □ Pending 2 □ Accident Investigation	28e. Dete of tnjur (Month, Dey	Year)	28b. Time Injury	W	uryet ork? ⊒Yes 2 □ No	28d. Describe	how injury occu	rred		
Divis If or Attendarder des Director	Certification:	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homlcide determined	28e. Place of injubuilding, etc	ry - At ho . (Specify	ome, ferm, s	treet, factory, office)	28f. Location City or To	(Street end Num own, Stete)	ber or Rure	el Route Number,	
Divisi To the Hospital or Atten- within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phy (Chact ant) 2 Medical Exam	reiciem the best of	xaminet	wledge, dee tion end/or it	th occurred et the t nvestigetion, in my	ime, date end plece opinion, deeth occu	e, end due to the urred et the time	ceuse(s) end m , date end plece,	enner es s	teted. the cause(s)	
To the within To the comple	Me	290. Signature and title of certifier		and the		29c. Licar	isa number		29d. Date signe	ed (Month,	Day, Yaer)	
		LAGUE	A Charle			RD 1	778		May 9,	1997		

State Registrar

31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture MAY 1 4 1997

Dr. Samuel Eng 9000 Franklin Square Drive Baltimore, Maryland 21237

30. Name and eddress of person who completed cause of deeth (item 23e) (Type, Print)



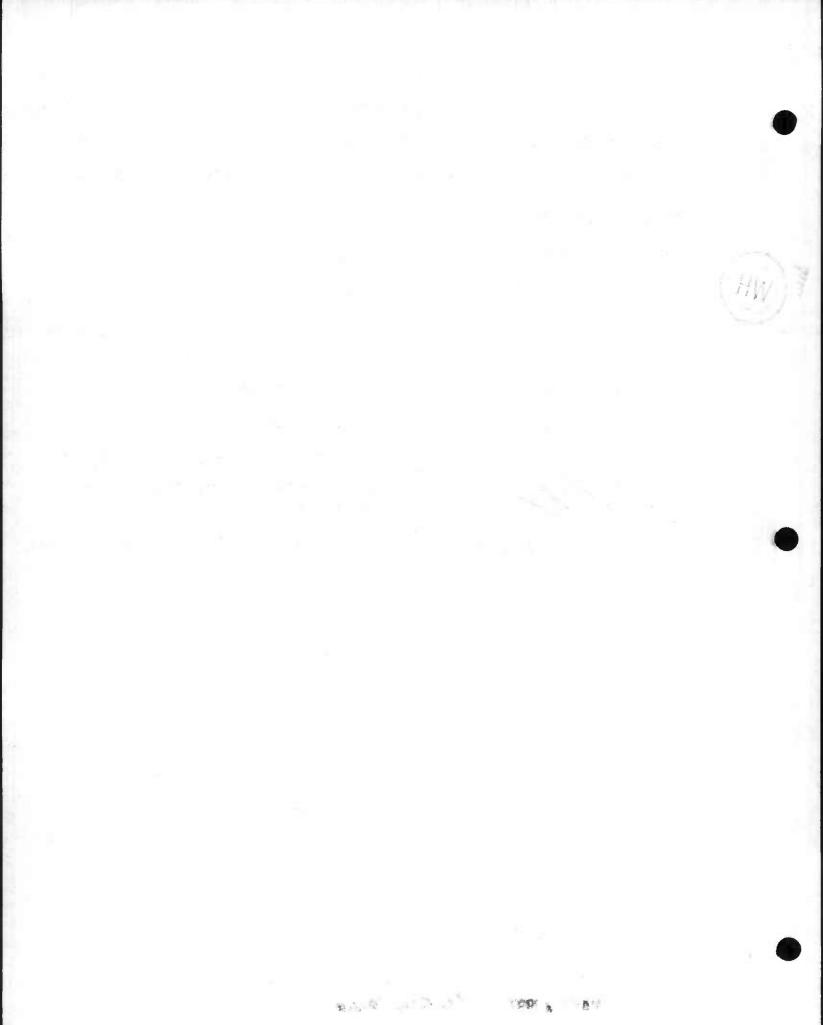
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State of Maryland / Department of Health and Mental Hygiene

14686

						Ce	rtificate	of L	Death			Reg. No.		1 1000
	1.	Decedent's Name (First, Midd						ate of De	ath		3. Time of Death			
		JOSEPH	T ATATO	ENCE		GAH	IAGAN .	TD		1 -	Month MAY	Day 8	1997	2 55 3 4
hysician /Medical axaminer 5.5 sector 20 MA		LAWR		her)	GAL	AGAIN,	JR	b. City, Town,				ty of Death	3:55 A.M	
		a. r domy realite (it not institute	on, give sire	ot and name	Dely			1	b. Ony, Town,	Of Locatio	al oi Dogs			
		1819 EDGEWOOI							PARKV:					
neral	5.	Social Security Number	6. Sex	2 F 7	. Age (In yrs. la		If Undar 1 \	Yaar Days	If Undar 24 I	Mrs. 8. C	ata of Birl Month, Da	th y, Year)	9. Birthp	laca (Stata or Foreign
ector		215-12-8430	XM	201	73	Yrs.		,,			/21/2			**
	JOSEPH 4a. Facility Name (If 1819 EDG 5. Social Security Nu 215-12-82 Usual Rasidence of I 10a. State MARYLAND 10e. Street and Num 1819 EDGE 11. Marital Status 1 Never Marrie 3 Widowed (Specific Elementary/Secon 12+1 GRA 17. Father's Name (If 19a. Informant's Name 19a. Informant's Name 21. Signature of Fun 23a. Page Enter Indent Cause (Fidsease or condition rasulting in death) Sequentially list content of the cause (Fidsease or condition rasulting in death) Sequentially list content of the cause (Fidsease or condition rasulting in death) Sequentially list content of the cause (Fidsease or condition rasulting in death) Sequentially list content of the cause (Fidsease or condition rasulting in death)	sual Rasidence of Decadent									,,			
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to fee	M	ARYLAND BAL	TIMOR	E		PAR	KVILLE							1 ☐ Yas 2 No
9	10	De. Street and Number		-		11110	10f. Zip Co	nde				10a Citizen o	What Cour	ntru?
												rog. Onicon o	Title Cour	niy i
a e		1819 EDGEWOOD						123	7.5				SA	
Š	1			Armed Ford		i. 13.	Was Deceden If Yes, specify	t of Hi	spanic Origin' n, Mexican, Pi	? (Specify uarto Rica	Yes or No n, etc.)	- 14. Ra		
		1 Never Married 2 Ma	rried	1 Yes 2 If Yes, Give	2 □ No		1□Yes 2□		Specify:					
		3 ☐ Widowed 4 ☐ Divorce	d	Year or Dat	es: WWII		X	3140	эрвену.			Spec	ITE	
9		15. Deceda	nt's Education	onn		16a. Dece	dent's Usual C	ocupa	tion			16b. Kind of	Business/înc	dustry
음		(Specify only highs				(Giva	kind of work of DO NOT use i	done d retired	uring most of	working		CONSOL	TDATE	O CTGAR
Ē		Elementary/Secondary (0-12)		College (1-	40r 5+)	CALI	ES REPE	ישכו	ביאים אחד ז	VIE.			IDUID	CIOAK
ပိ	1	12th GRADE. 7. Father's Name (First, Middle	Lond			SALI	ED KEFF	(Ca)			-4. 4.47-4-41-	œ		
å	i I	r. I alliei s Italile (riist, Middle	, Lasi)						16. Mothers	ivame (Fir	st, Middia,	Maidan Suma	inie)	
2		JOSEPH L. GA	HAGAN	, SR.					SARAI	H BAR	LOW			
1.		9a. Informant's Name/Relation	ship (Type,	Print)		19b. Mailie	ng Address (S	treet a				er, City or Tow	n, State, Zip	Death JOST 3:55 A.M Death JTIMORE Birthplaca (Stata or Foreign MARYLAND 10d. Inside City Limits 1 Yes 27 No at Country? American Indian, White, etc. WHITE Thess/Industry ATED CIGAR Approximate Interval Between Onset and Death JOST BLVD. Approximate Interval Between Onset an
Sician edical miner 4a. Facility 181 7. Social St. 215—1 10a. State 10a. State 10a. State 11a. Marital 1 New 3 Wide 17a. Falmer 17a. Fal					101	2 55 65	7001					03.00		
	20	PATRICIA M. GA	HAGAN		WIFE 20b. Pla	LOT Dispo	EDGEV	NOO!	D ROAD			RE, MD		•
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata cemetery, crematory or other place)													wiii, Giaie
ulary														le, MD
	2	1. Signature of Funeral Service	Licensee			20	Name and A	Addres	s of Facility					
8		1//	1			J	OHNSON	FU	NERAL	HOME	852	1 LOCH	RAVEN	BLVD.
	+.		1			TC	WSON,	MD	21286				,	
	1	shock or beart failure. Lis	t only one c	ause on ea	used the death. ch line.	Do not ent	er the moda o	it ayınç	, such as car	diac or res	piratory at	rrast,	1	Interval Between
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cal	lr d	nmediate Cause (Final	(TYY	NOS, 2,	7110	er our	110) × 1 9	W/1 / 14)	BRIN	1 Hope	weel	54 Jay
er	Li	asulting in death)	a	*							/		1	V
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xar	S	equantially list conditions,			Due to (or	as a consac	juenca of):							
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Ica	that initiated events resulting in death) Last Due to (or as a consequence of);													
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<u>a</u>	_												I	
18	Pa	art II. Other stgnificant conditt	b	th but not result	ting in the u	nderlying caus	se give	n In Part I.		23b. Dld 1	tobacco use c	ontribute to	the cause of death?	
P.											10	Yes 2016	3 □ Prot	bably 4 Unknown
7	-			-						_		a.r		
leted b											24a. Was	an autopsy	24b. We	ere autopsy findings
ete												rmed?	CO	allable prior to mpletion of cause
lgu														
Ö											101	res 2000	10	Yes No
		5. Was case referred to medica	al						26. Place of	Death (Ch	eck only o	nne)		
80		examiner?	Hosp	ital:		D/O · · ·		Othe						
		Mannes of Death		1 🗆 Ing		R/Outpatier			4 DELINUISIN			dance 6 0		V)
O	21	Natural 5 Pendi		Ba. Date of (Month,	Day Year)	28b. Time of Injury		Injury Work		280.	Describe I	now injury occi	urred	
TE ST		2 Accident Investi	igation				M	1 🗆 1	'es 2 □ No					
= =		3 Suicide 6 Could 4 Homicide determ		8a. Placa o	f Injury - At hom	ne, farm, str	eet, factory, of	ffice					ber or Rura	I Route Number,
e L		- CHOMICIOS		building	g, atc. (Specify)					'	City or Tov	vii, Siare)		
	20	Pa Certifier	na Physials	n: To the b	net of my board	adaa dasib	occurred at a	ha tim	a data and -!	900 000	lug to the	onunnin and	2000000000	etad
Ica	1 2	(Uneck only 2 Medical	Examiner:	On the bas	is of axamination	auga, daath n and/or in	astigation, in	my op	a, data and pl inlon, daath o	ace, and d eccurred at	tha tima,	causa(s) and n data and place	nannar as st , and due to	the cause(s)
8	-	Unity)		and manne	r stated.									
2	25	b. Signature and title of portifie	24	20			29c. Li	icense	number	7		29d. Data sign	ed (Month,	Day, Year)
0		V (ChoVII)	190	7				V	1101	-		5-0	×91	
N o	100	alle		-1-4	at decided	20-1 77	D. Carl	-					1	
	30. Nama and address of person who completed causa of daath (Itam 23a) (Type, Print) 120 Sister Pierre Drive # 506 Towson, WD 21204													
							1 NOSV	IN	D 212	04				
State	31	. Date filed (Month, Day, Year,	4	32. Reg	istrar's Signatu	re	30							
egistrar		MAY	1 4 19	3/	gistrar's Signatu	Baurdson	-Mande	6						

Registrar



State of Maryland / Department of Health and Mental Hygiene 14687 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month 35 am STEPHEN SATTUS /Medical 4e Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** tosp mai Baltimore City N/A 5. Social Security Number If Under 1 Year 8. Date of Birth Sept. 18,1927 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Hours 220-18-2743 1 Ø M 2 □ F Months Min. 69 Director Maryland Usual Rasidence of Decedent 10b. County 10c. City. Town or Location 10d. inside City Limits Middle River Baltimore Maruland Fulleral Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21220 United States 7010 Greenbank Road 12. Was Decedent Ever In U,S. Armed Forces?
1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: ₩₩7 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à Specify: 3 Widowed 4 □ Divorcad WWII White Completed 16a. Decedant's Usual Occupation
(Give kind of work done during most of working
lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steelworker Steel Industry 6 Years 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumame) Be Pages 1 and 2 should be nent of Health and Mental is marked Alice Cherry Stephen J. Gattus, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tran-once. 7010 Greenbank Road Middle River, MD 21220 Stephen J. Gattus/Son 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Sacred Ht. of Mary Cem. 5/14/1997 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 32. Name and Address of Facility Duda-Ruck Functal Home of Dundalk, Inc. Johnson 7922 Wise Ave Dundalk, Maryland 21222 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. **Physician** /Medical Immediate Causa (Final disease or condition rasulting in daath) Examiner Be Completed by Physician/Medical Examiner signed by the attending physician and the detached for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uea contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Wera autopsy findings eveilable prior to completion of cause of daath? 24a. Was an autopsy performed? cusease 2200 1 Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case refarred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Mipatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Manner of Daath 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 1 SVatural 5 Pending 24 hours after death. Funeral Director: A Investigation 1 ☐ Yes 2 ☐ No 2 Accidant filled in by the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicida 29e. Certifler (Check only one) Medical completely To the Within 2 To the 29b. Signature and title of sertifie 29c. License number 29d. Date signed (Month, Day, Year) 452402321429023 MD 30. Name and addrass of person who usa of death (Item 23a) (Typa, Print) Michael Zang Sirai Hospital 2401 W Belvedere Ave. Baltimore, MD 21209

Registrar

31. Date filad (Month, Day, Year) MAY 1 4 1997

32. Registrar's Signature Julia Savidson Rendere

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State of Maryland / Department of Health and Mental Hygiene 4688 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month WILLIE AALL 97 05 12 /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NSG. + REHAB BALTO RAVENWOOD If Undar 24 Hrs. 6. Sex. 1 M M 2□ F 5. Social Sacurity Number If Under 1 Year Birthpleca (Stata or Foraign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Dey, Year) **Funeral** Days Hours 215-72-0158 Yrs Director 40 MD Usual Rasidence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or thems 23s or 28s-f shot traumatic event, the Modical Examiner must be notified at NA Baltimore XIXYas 2 No Director mD. 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1434 North Bond Street 21213 USA Funeral 12. Was Decedant Evar In U.S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Peges 1 end 2 should be filed within 72 hours efter onent of Health end Mental Hygiene. Int: If Item 27 Is merked other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Detes: altimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Dacedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Eiamentary/Secondary (0-12) Collega (1-4or 5+) 9th Grade Laborer various trades 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meldan Surnama) Henry В. Hall Estelle McMicken 19a. informent's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rurel Route Number, City or Town, Steta, Zip Code) nt of Health e If item 27 is or other tra McMiken 1434 N. Bond Street Baltimore, Md. Estelle 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 ☐ Cramation 3 ☐ Removal from Stata Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 05-15-97 Dundalk, Md. permit. 22. Nama and Addrass of Facility 21. Signature of Fusieral Sarvice Licenses Baltimore, Maryland 21202 Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or Meart failure. List only one cause on each line. WM.C.March FH 1101 E. North Avenue Approximata **Physician** /Medical Immediata Causa (Final Progressive Dementic Y240 diseasa or condition resulting in death) Examiner pital or Attending Physician: The law requires that the death certificeta be executed ours after death.

eral Director: After this certificate hes been signed by the attending physician and filled in by the functed firector, page 2 should be deteched for use as the burish-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last P.O. Box 68760. Physician/Medical Dua to (or as a consaquence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Chronic Read failure 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Oval thrush 1 ☐ Yas 2 ☐ 110 Be 25. Was case refarred to madical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 9 27. Manner of Death 28c. injury at Work? Certification: 28a. Dete of injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred 1 Matural 5 Pending Invastigetion 1 Yes 2 No 2 C Accident 20 FITUVS 6 Could not be datarmined 3 Suicide 28a. Placa of injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicide To the Hospital or within 24 hours aff To the Funeral Df completely filled in 1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, date end plece, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifier Medical 29b. Signatura and titla of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 006966 30. Nama and addrass of person who complated causa of death (itam 23e) (Type, Print) Cathadral St. Baltimon MO 21201 1001 31. Date filed (Month, Day, Yaer) State

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Registrar

MAY 1 4 1997

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 9:05 am ETTA HULSEMAN MAY 1997 11 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** 933 S. Oldham Street Baltimore n/a If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/9/1925 If Under 1 Year 5. Social Security Number 9. Birthpiece (State or Foreign Country)
W. Va. 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F Months Days 216-22-5114 72 Yrs. Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Examinar must be notified at 1XXYes 2 No Director Md. Baltimore n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 933 S. Oldham Street 21224 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24.7No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Biack, White, etc. e filed within 72 hours efter al Hygiene.
other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2XNo Specify: ρ Specify: 3℃Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Jeweler's Assistant Prince's Jewelry permit. Peges 1 and 2 should be file Department of Health end Mental Hy, Important: If Itam 27 Is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Williston Unknown 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Frank Hulseman, Jr. / Son 2409 Poplar Road, Baltimore, Maryland 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Holly Hill Cemetery 5/15/97 Baltimore, Md. 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Lilly & Zeiler Inc. 700 S. Conkling Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? signed by I ances of the rection 1 Yes 2 No 3 Probably 4 WUnknown Records, ò Estructure Julin many Disease 24b. Were eutopsy findings eveilable prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 MResidence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Menner of Death 1 Neturel 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) á 4 Homicide within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) and manner as steled.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) and manner stated. 29e. Certifier 29b. Signature and title of Pertifier 29d. Date signed (Month, Day, Year) Milarin. 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

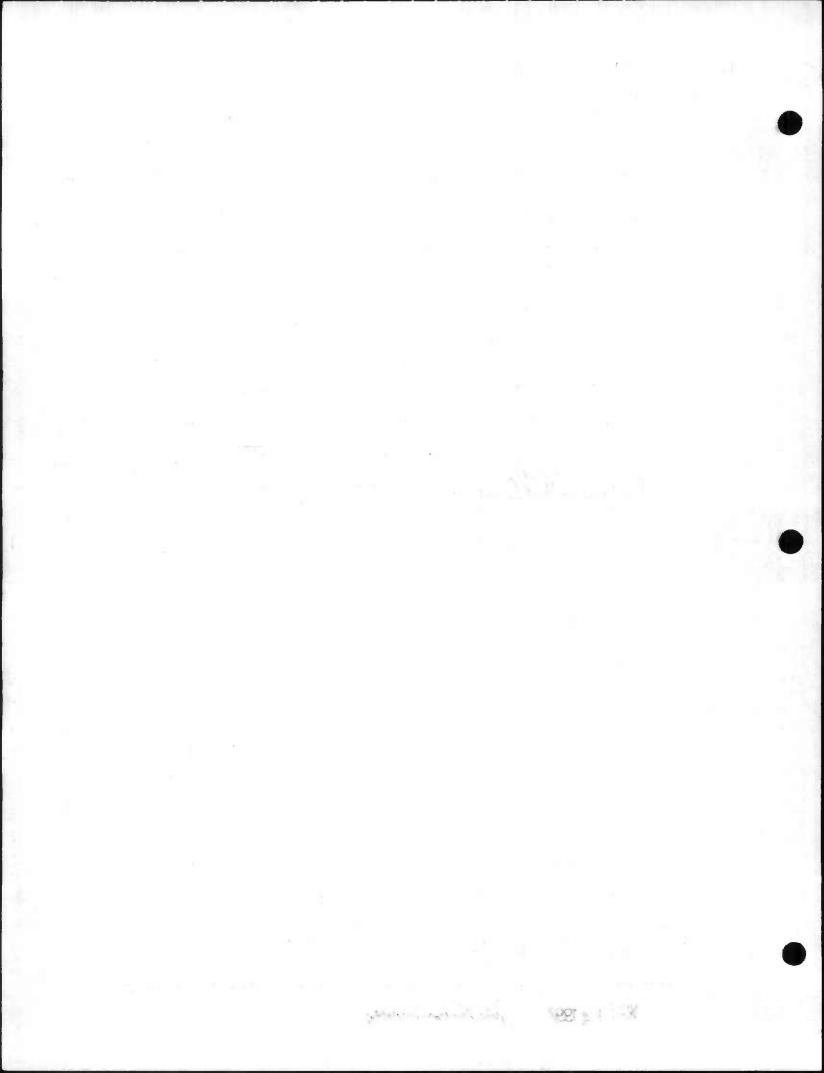
MELITO M, JORNES, MD 441 5. ELLWOOD ANE, BALTO, MD 21224 31. Dete filed (Month, Day, Year) State Registrar

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State of Maryland / Department of Health and Mental Hygiene

14690 Item20b 5-14-97 FilmG747 W.H.Per F/H Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev **Physician** Month Ethel Heese May 11, 1997
4b. City, Town, or Location of Death 4c. Co /Medical 8 PM 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** 3 Southerly Court. Unit 105 TOWSON BALTIMORE 5. Sociei Security Number If Under 1 Year if Under 24 Hrs 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Birthpiece (State or Foreign Country) , Funeral Deys Hours 1□ M 2□ F Yrs. Director 102 05 0087 83 March 14,1914 NEW_YORK Usuel Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinat must be notified at MARYLAND BALTIMORE 1 Yes 2 Tho TOWSON Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 3 Southerly Court, Unit 105 21204 USA by Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes Y ☐ No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No WHITE 3 ☐ Widowed 4 ☐ Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Albert Golly 2 Hannah Golly Jensen 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Margaret J.Concepcion/ Daughter 10860 Sandringham Rd., Cockeysville, MD 21030 20b. Piece of Disposition (Name of cemetery, crematory or other piece)

George Washington Mem. Park
1007 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 Dopation 5 Other (Specify) 5 Other (Specify) Paramus, New Jersey 21. Signature E 22. Name end Address of Fecility Lemmon Funeral Home of Dulaney Valley, Inc. fatt like seese, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, ure. List only one cause or each line. Approximete Intervei Between Onset end Deeth **Physician** /Medical Immediate Owas Final disease or condition resulting in deeth) rest Examiner Due to (or es a consequence of) Acus The law requires that the death certificate be executed bunial-transit Sequentielly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Box 68760. ettanding physician for use as the buria Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach - Canela 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? Deed cartificate 1 ☐ Yes 200 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director Be 25. Wes cese referred to medical 28. Place of Deeth (Check only one) 10 1 Yes 2 No Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death Certification: 28b. Time of 28d. Describe how Injury occurred 28c. fnjury et Work? After 1 Neturei 5 Pending death. investigetion 1 Yes 2. No after death Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medical 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) ş 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) 0 30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Stanley R. Steinbach, MD PA, 21 Crossroads Drive, Owings Mills, MD 21117 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State relia Sevidoon Registrar



State of Maryland / Department of Health and Mental Hygiene 0.7

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l	Examir		4a. Facility Nama (If not institution, given S226 CORN 6 5. Social Sacurity Number 6.5	NALL ROAL		If Under 1 Year		BALK	BA	LTim		
	Director		006-67-2296 Usual Rasidenca of Dacedant		3 Yrs.	Months Days	Hours Min	8. Dete of Bir (Month, Da AUG. 15		Country) MA	(Stata or Foreign	
di.		tor	10a. Stata 10b. County BAL;	TIMORE 100. CH	ly, Town or Loc	DUNC	ALK				Inside City Limits 1 ☐ Yes 2 🕅 No	
N	A 43)lrec	10e. Street and Number			10f. Zip Coda			10g. Citizan of V	Vhat Country?		
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020	urs after da af, or flams Examiner m	by Funeral Director	11. Merital Status 1 □ Naver Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Wes Decedant Evar in U Armed Forcas? 1 ☑ Yas 2 ☐ No If Yas, Give Yeer or Detas:		/es Decedant of Yas, specify Cub	Hispanic Origin? (S een, Maxican, Puar Specify:	Specify Yas or No to Rican, atc.)	- 14. Rac Blac Specify	e - American le kk, Whita, atc.		
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Ma	d 2 s D an T ls r		19a. Informant's Name/Raletionship (STEVEN HUTC	HIDS - SON		h 6 -	t and Number or R	RD,	ROSE DA		MD 2123	
ē,	Heat Jam 2		20a. Mathod of Disposition	20b. F	Place of Dispos	ition (Nama of		Data	20c. Location -			
altimore	t. Pages tment of tant: If II		1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif	y) OF	AK LA			5/14/97	BALT		no	
Bal	Deparation of the control of the con		21. Signature of Funaral Sarvice Licer	. Conne	lly 5	110 50	y fune	POINT	Rd.	CAND	ALK Z	
	Physician /Medical Examiner)r	23e. Pertif. Enter the disease or com- shock, or haart failure. List only tmmediete Causa (Final disease or condition resulting in death)	a CRIVER	1	he NA	sophoe			Inta	arvat Batween set and Deeth	
Box 68760,	n certificate be executed anding physician end use es the buriel-transit	by Physician/Medical Examiner	Sequantially list conditions, if any, laading to Immediata causa. Entar Undarlying Cause (Disaasa or Injury thet initieted avants rasulting in daath) Last	c	or es a consequ							
	death he etten	sicla	Part It. Other significant conditions of	ontributing to death but not ras	ulting in the un-	darlying causa gi	van in Part I.	23b. Dld	tobacco use cor	ntributa to the	cause of death?	
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Records,	been should	Completed !							an autopsy med?	availab	autopsy findings ola prior to etion of causa th?	
E	ilclan: The lev certificate has rector, page 2	Com						10	Yas 200 No	1 □ Ya	s al No	
Vital	ysician: s certific director,	Be	25. Was casa rafarred to medical examiner?	Mo emited.		To		ath (Check only o	ona)			
of	\$ 000	ation: To	1 Yes 2 No 27. Mennar of Death 1 Netural 5 Panding 2 Accidant invastigation	28a. Data of Injury (Month, Day Year)	ER/Outpatient 28b. Tima of Injury	28c. tnju		doma 5 ☐ Rask 28d. Dascribe	dence 8 DOth	er <i>(Specify) }-</i> red	dospiec	
Division	or Attendi	Certification:	3 Suicida 6 Could not b 4 Homicide datarmined	e 28e. Place of Injury - At he building, atc. (Specif	oma, farm, stre	et, factory, office		28f. Location (. City or Tot	Street and Numb vn, Stafa)	er or Rural Ro	ute Number,	
	To the Hospital or Attending Ph within 24 hours effer deeth. To the Funeral Director: After thi completely filled in by the funeral	edical C	29a. Certifiar (Check only one) 16 Certifying Ph	ysictan: To the best of my kno ntner: On the basis of exemina and menner stated.	wledge, deeth tion and/or Inve	occurred at the ti estigation, In my	ma, data and place	e, and dua to tha urred at tha tima,	cause(s) end ma data and place,	nner as stated and due to the	1. cause(s)	
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	1		30. Name epd address of person who	complated cause of death (Itan	7 23a) (Typa, P		0.1	9 //	~	2170	,,	

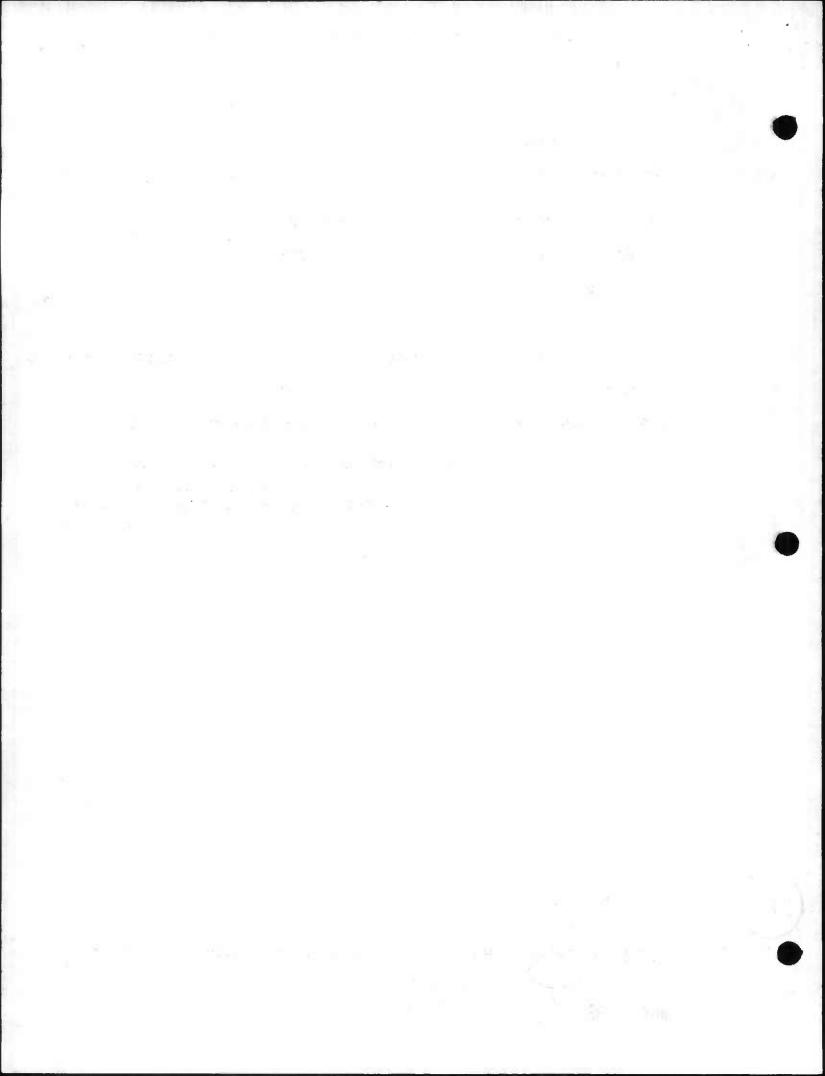
State Registrar

Parker SERVICE SERVICE

State of Maryland / Department of Health and Mental Hygiene

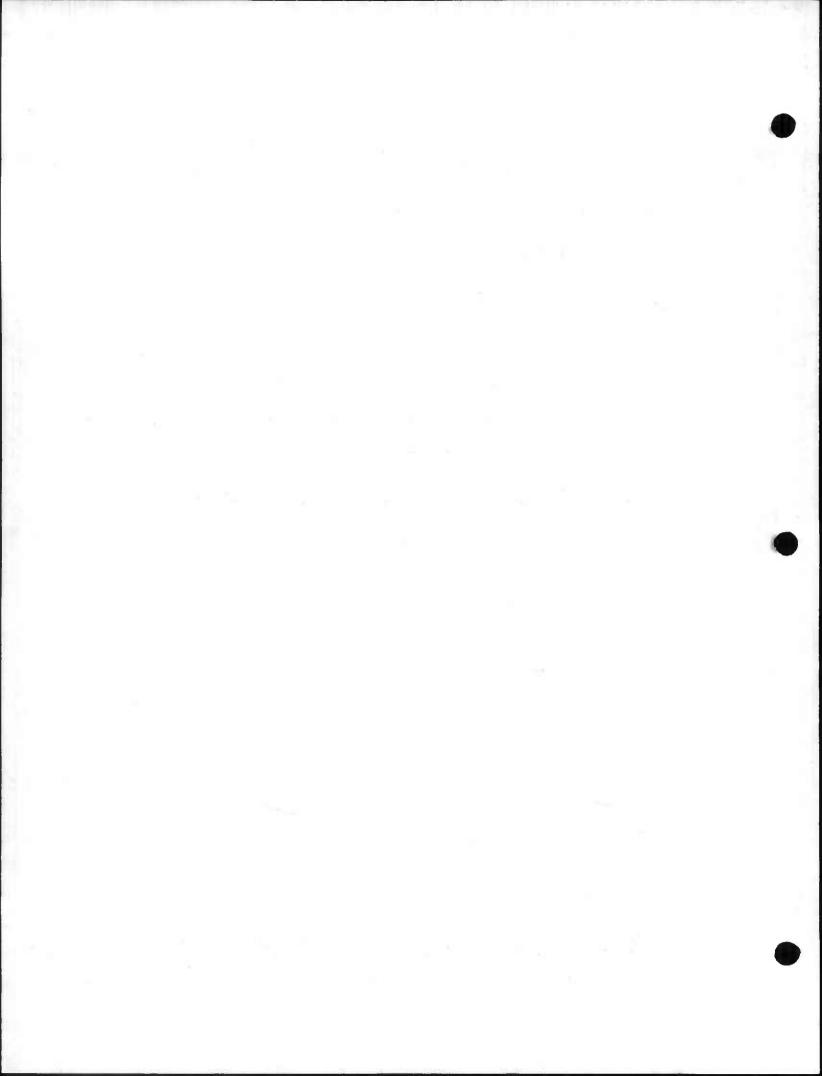
Item4c 5-14-97 FilmG747 W.H.Per F/H Certificate of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Deeth **Physician** Month Charles G. Jules 3526 PM 1997 /Medical 4a. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Huspital Baltomore Baltine R N/A Johan if Under 24 Hrs. Hours Min. If Under 1 Year 6. Sax 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XX M 2□ F Months Days 220-12-2456 Yrs. Director 73 NOV. 10, 1923 MD Usual Rasidanca of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or flems 23a or 28a-f show traumatic event, if a Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Director BALTIMORE BALTIMORE 10e. Straet end Number 10f. Zip Coda 10g. Citizan of What Country? 3509 PHILIPS DRIVE 21208 U.S.A. Funeral 12. Was Decedanf Ever in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) Rece - American Indien, Bleck, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or thei any injury or other traumatic event. 1 ☐ Navar Married 2 Married 1 ☐ Yas 2 XNo Baltimore, Maryland 21215-0020 1 ☐ Yas v☐ No Specify: Specify þ WHITE 3 Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) 15. Decedant's Education (Spacify only highast grade complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) OWNER WHOLESALE BEAUTY SUPP 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be SYDNEY JULES ANNA GOLDENBERG 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3509 PHILIPS DRIVE MARJORIE JULES / WIFE BALTIMORE, MD 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) BNAI ISRAEL (MISHKON) 5/12/97 BALTIMORE, MD 21. Signetura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrasf, shock, or heart failure. List only one ceuse on each line. Approximata Interval Batween Onsat end Death **Physician** Myocardial Infarction /Medical Immediata Causa (Final 20 minutes diseese or condition rasulting in daath) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of). P.O. Box 68760, Physician/Medical Dua to (or as a consequance of) Part II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco usa contributa to the causa of death? signed by 1 ☐ Yee 2 ☐ No 3 Probably 4 ☐ Unknown þ 24b. Ware autopsy findings available prior to should should Completed 24a. Wes en eutopsy complation of causa of death? 1 Yas 2 No 1 ☐ Yas 2 No wision of Vital 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: 1 (inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) 1 Yas 2 No funeral 27. Mannar of Daath 28a. Data of Injury (Month, Day Yaar) 28b. Time of 28d. Dascribe how Injury occurred Certification: 28c. Injury et Work? 1 Natural 2 Accidant 5 Panding 1 ☐ Yas 2 ☐ No deeth. invastigation a proper 6 Could not ba 3 Suiclda Location (Streat and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 4 Homlcida Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examples: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signature and titla of certiflar May AS-2402321-DS-9034 30. Nama and address of parson who completed causa of death (Itam 23a) (Type, Print) Danny-Song Sinul Hespita 31. Data filed (Month, Day, Year)
MAY 1 4 1997 32. Begintrar's Sid Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Physician MAY 9, 130 CARRIE **JACOBS** /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** PIKESVILLE NURSING HOME BALTIMORE BALTIMORE If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Yeer 8. Defe of Birth (Manua Deg Year) 1901 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 1 □ M 2 🗓 💢 🤾 95 Yrs. Director 213-74-6946 Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show notified at MD N/A BALTIMORE 1 No Director 28a-f 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Counfry? 6 the Medical Examiner must be 4001 CLARKS LANE; APT. 401 21215 USA items 23a Funera 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, Whife, etc. filed within 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ X o If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 "naturel", or 1 ☐ Yes 2√No þ Specify: WHITE 3 X Vidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other treumatic event entered." Elementary/Secondary (0-12) Cotlege (1-4or 5+) HOMEMAKER OWN HOME 12 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be JOSEPH KRAMER REBECCA **KRAUSS** 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, Cify or Town, State, Zip Code) DORIS ROSENBLATT (DAUGHTER) 4 POMONA NORTH, APT.10; BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete XXBurlel 2 Cremetion 3 Removel from State (ANSHE EMUNAH) AITZ CHAIM 5-12-1997 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Fyneral Service Ling 22. Name and Address of Facility SOL LEVINSON & BROS, INC. uch 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Betw **Physician** /Medical Immediete Cause (Final Cerebral Throm hos C disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner physician end the buriel-transit requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): USB P.0. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed l Records. þ Completed 24e. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of deeth? The law page 2 ificate 1 Yes 1 ☐ Yes 2 ☐ No /Ital Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA ö 28e. Dete of Injury (Month, Day Yeer) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Waturel 5 Pending 117 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital an within 24 hours and To the Funeral Discompletely filled in edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as atated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29b. Signeture end title of certifie 29c. License number 29d. Dete signed (Month, Dey, Year) mpleted cause of deeth (Item 23a) (Type, Print) ARKHEIGHT Are 21200 (Month, Day, Year) 1 4 1997 State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14694 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 2 **Physician** 6:15 PM /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Medical System

6. Sex 77. Age (In yrs. last birthday) It Undar 1 Year
Morths | Days Baltimore University 5. Social Security Number If Under 24 Hrs. Birthplaca (State or Foreign Country) **Funeral** Days 1 M 2007 Year) 214-20-7609 Usual Residence of Decedent Director VIRGINIA 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yas 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? Fages 1 and 2 should be filed within 72 hours effer death with 1 month of Health and Mentel hygiene.

The files 72 is marked other than "natural", or flems 23s or the property of other traumatic event, the Medical Example 2405 WESTWOOD U.S. A AVE. 21216 12. Was Dacedant Evar In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 Yes 2 No If Yas, Giva Year or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No 3 Widowad 4 □ Divorcad Specify: BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) THE MART StorE 12 PERSON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be STERLing John LORENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) CAROLYNKING - DAUGHTER 2405 WEST Wood AVE. BALto, md. 21216 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removal from State Department of 4 ☐ Donation 5 ☐ Other (Specify) CROWN Ville, Md. 22. Name and Addrass of Eschity adway Bacto. md. 21213 JEFFMILER P. C. FYNERAL HOME+SERVICE 23a Party Entry the lisbase, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrast, shock, or near failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner by Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of) Box 68760, Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown)iabetes Division of Vital Records, 24b. Wara autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yas 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case rafarred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only ona) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 RR/Outpatient 3 DOA 28a. Data of injury (Month, Day Yaar) 27. Manner of Death 28d. Describe how injury occurred 28c. injury at Work? To the Hospital or Attending F within 24 hours effer death.
To the Funeral Director: After t 1 Natural 5 Panding investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Placa of Injury - At home, farm, street, factory, offica building, etc. (Spacify) filled in by 4 - Homicide

31. Data filed (Month, Day, Year) State Registrar

29a. Certifiar

(Check only

29b. Signature and title of cartifier

Medical

22 S. Greene Street Baltimore, Md. 21201 Browne

on who complated causa of daath (Itam 23a) (Type, Print)

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and piaca, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and piace, and dua to tha causa(s) and manner stated.

29d. Data signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

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Si Regis	tate trar	30. Nema and address of parson who completed on Smitha Subramany 31. Data filed (Month, Day, Year) 32. MAY 1 4 1997	agisti ins Signatu	Mande	7								

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 0.7

			Certifi	cate of Death	Reg.	21	14696
	Physici	an	1. Decedent's Neme (First, Middle, Last) LEONARD J. KULACKI, S.	0	2. Date of Deeth	Dey Year	3. Time of Death
الد	/Medi	al	LEONARD J. KULACKI, S. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L	MAY /C	4c. County of Death	1:15 PM
7	Examir	ier	COLLEGE MANOR, INC.		ERVILLE		MORE
	Funeral Director		5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) 11 Mo		8. Deta of Birth Month, Dey, Ye JUNE 16, 1	9. Birth	place (State or Foreign intry) VLAND
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020	72 hours after death with the Maryland natural', or ferns 23a or 2844 show dical Examoner must be notified at	by	1 Never Merried 2 Married 1 1 Yes 2 No	Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto as 2 No Specify:	pecify Yes or No- Rican, atc.)	14. Race - Amer Bleck, White Specify: Wh	, etc.
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	id be filed lental Hygi ked other ic event, t	To Be Completed	17. Father's Name (First, Middle, Last) LEONARD KULACKI	18. Mother's Nam	A LIPI		
Maryland	d 2 shouth and M	-	19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Ad	dress (Street end Number or Run BALDWIN MILL	rel Route Number, Ci	ity or Town, Stete, Z	
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al R	sician: The law certificate has t irector, page 2 s				1 ☐ Yas	2 ☑ No 1	☐ Yes 2☐ No
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ion of	는 무를		27. Manner of Deeth 1 InNatural 5 Pending (Month, Dey Year) 2 Accident investigation	28c. Injury et Work?	28d. Describe how i		Maner
Division	after des Director d in by th	Certification:	3 Suicide 4 Homloide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, female building, etc. (Specify)	ectory, office	28f. Location (Stree City or Town, St	t and Number or Ruitele)	ral Route Number,
1	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai C	29e. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurrence of examination and/or investigence of memory stelled.	urred at the time, dete and plece, etion, in my opinion, daeth occur	end due to the cause red at the time, dete	e(s) and manner as and plece, end due	stated. to the cause(s)
1	To the within To the compl	Me	29b. Signatura and titla of certifier	29c. License number	29d.	Data signed (Month	, Dey, Year)
	· . V		32 Jourens	024733		1/12/9	7
(101		30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)	Francist 1	ne no	uson N	d 21286
	Sta Registr		31. MANed (Marti CQ Year) July 10 Hondray Shopped		1		

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State of Maryland / Department of Health and Mental Hygiene

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							Ce	rtificat	e of	Death			Reg. No.	21	1 4	03	
	Physic	ion	1. Decedent's Name (First, A	fiddle, Las	t)	. 1						2. Date of De		Voor	3. Time	e of Death	
	Physic /Medi		KUTI	+	KELL	MAN						MAY	a g	1997	8!	- My	
	Exami		4a. Fecllity Name (If not insti-			nber)			1	4b. City, To	A .	ocation of Deat	h 4c. Count	y of Death			
	212		SINAL	-	PIPAL	OF	PALTI			ורו		MORE		AHOR	EC	ITY	
	Funeral Director		5. Social Security Number 217–36–3616 Usual Residence of Deceder		ж аддғ	7. Age (In yrs 84	. last birthdey, Yrs.	Months	1 Year Days	if Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De AUG •	th Year) 29, 1912	Coun	ntry)	te or Foreig	
	yland	1	10a. State 10b. Co			10c. C	ity, Town or L	ocation		-		-		1	0d. Inside	a City Limit	
	the Marylan 28a-f show	tor	MD I	I/A			BALTIM	ORE							1 🔯 💥	es 2 N	
	or 282	Director	10e. Street and Number					10f. Zip	Code				10g. Citizen of	What Cour	ntry?		
	ith will		2500 W. BELY	EDER	E AVE;	APT. 6	10		2	21215			USA				
	items items	Funeral	11. Marital Status		12. Was Dece Armed For	dent Ever in U	J,S. 13.	Was Deced	ent of h	tispanic Or	igin? (Sp	ecify Yes or No Rican, etc.))- 14. Ra			ı,	
0200-61212	air, or	by	1 ☐ Never Married 2 ☐ WWw.Widowed 4 ☐ Divo		1 ☐ Yes If Yes, Give Year or Da	2 X X		1□ Yes 2				Tribair, 5to.,				E.	
2	72 Par	Completed	15. Dece (Specify only h	dent's Edu	cation le completed)		16a. Deca	dent's Usua kind of wor	l Occup	oation during mos	t of work	cina	16b. Kind of E	usiness/Inc	dustry		
V		mpi	Elementary/Secondary (0-		College (1-	4or 5+)		DO NOT us		•							
	e filed withing the hygiene. other than went, the M		17. Father's Name (First, Mic	dle (set)				MANIC	JRIS		nda Atam	o /First Middle				-	
	d d d	Be	MEYER	ure, Last)		A F TO	שמפ										
5	d 2 should be th end Mente 7 is marked traumatic ev	2	19a. Informant's Name/Relat	ioneblo /Ti	una Print)	ALP	-	an Addrone	(Ctront		ARAF				Ondel		
S S	d2 sther		HARRY KELLM														
שַׁ	-155		20a. Method of Disposition	774 (12)	OIV)	20b.	Place of Dispo	sition (Nam	e of		1. 5	Date					
2	9		1 X urial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other plece)														
			21. Signal of Juneral Ser	- 1	-	\/A		2. Name and				-11-19					
Ď	permit. Departr importa any inje		XIIII	17	nua			SOL LE	EVIN	ISON &	BRC	S., INC	3.				
	-		23a. Part 1. Enter the diseas	or compl	lications that ca	Tused the dea	th. Do not en	8900	REI	STERS	TOWN	RD; PI	KESVILI	E, MD			
	Thusleion		23a. Part1. Enter the disease shock, or heart failure.	List only o	nectuse on ea	ich line.	(II. DO 110(BIT	ter the mode	o dyn	ig, sucii as	cardiac	or respiratory a	rrest,	1	Interval F	Between	
	Physician /Medical		Immediate Cause (Final												,/		
	Examiner		disease or condition resulting in death)		9.	ago Ca	ioner	my	w	vic					14	our	
		je.			Cla	Due to (or as a conse	quence or):	1.	AMO	04.0	Doin x	4	1	2 /	2	
	cuted	Examiner	Sequentially list conditions		b. 7/F	Due to (or as a Jonsey	uenca v	100	Mass	87	peng "	. (5 20	7	
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00/00	icate be executed physician and s the buriet-Iransit	lca	Due to for an a conception of										2004	MIC.			
5	ertifica ling pl	Mec	Cause (Disease or injury to the initiated events resulting in death) Last Due to (or as a consequence of):														
	that the deeth certificate be executed ed by the ettending physician and detached for use as the buriel-transit	Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did 1															
	a dee	sici	Part II. Other eignificent conditions contributing to death but not resulting in the underlying cau								l.	23b. Did	ing x4 3 days ing disease chronic 23b. Did tobacco use contribute to the cause of death?				
	that the de ned by the c detached	Phy										1 🗆	Y00 2 No	4c. County of Death Accounty of Death 10d. Inside City Lim 1 M Mes 2 1 10d.		Unknow	
ń	Se Ded	by							d tobacco use contribute to the cause of des Yee 2 No 3 Probably 4 Unkn								
5	v requires been sign should be	Completed										24a. Was	an autopsy	ava	ailable prid	or to	
ט	2 S S	ple												of e	mpletion of death?	of cause	
_	0 - 0	Con										10	Yes 2 No	1 🗆]Yes 2	No	
NI P	certificete rector, pag	Be (25. Wes case referred to med examiner?	lical						26. Place	of Deat	h (Check only	one)				
5	Physician: this certific ral director,	2	1 Yes 2 No	ŀ	lospital:	patient 2	ER/Outpatier	nt 3 DO	A Oth	ner: 4 🗆 Nu	ırsing Ho	ome 5 Resi	dence 8 Oth	ner (Specif)	y)		
=	fer the		27. Menner of Death 1 Natural 5 ☐ Pe	ndina	28a. Date of (Month)	Injury Dey Year)	28b. Time o	f 28	Bc. Injur Wor	y et rk?		28d. Describe	how Injury occur	тес			
DIVISION	eath. or: After the fune	cati	2 Accident Inv	estigation				М		Yes 2	No						
Ĕ	O CO	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e. Placa o buildin	of Injury - At h g, etc. (Speci	ome, farm, str	eet, factory,	offica			28f. Location (: City or Tox		ber or Rura	I Route N	umber,	
1	E LE	Ö									-						
	A Paris	edical	29a. Certifier 1 Certifier (Check only one)	fying Phys cal Exami	alcian: To the t ner: On the bas and mann	sis of examina	wiedge, deati ation and/or In	n occurred a vestigation,	t the tir In my o	me, date an pinlon, dea	d place, th occuri	and due to the red at the time,	cause(s) and m date and placa,	enner as st and due to	ated. the caus	e(s)	
1	100	2	29b. Signature and title of	Fior D				1000000		e number			_				
) _	-3		30 Name and address of	the	m-	of door in	2 226) (7:	Dains\	DA	1057	4		MAY	9,19	97		
			30. Name and address of per	I I WIO CO	A Z	0.04		e lint)		Carr	HI	HONCOMA	2 mis -	מנוש	EU	7) 21:	
	Sta	ite	31. Date filed (Month, Day, Y	ear)	. 32 Re	gistrar's Signa				7/N	11 1	W 27 1 [1]	11/11	r r ug n	- 100	0 40	
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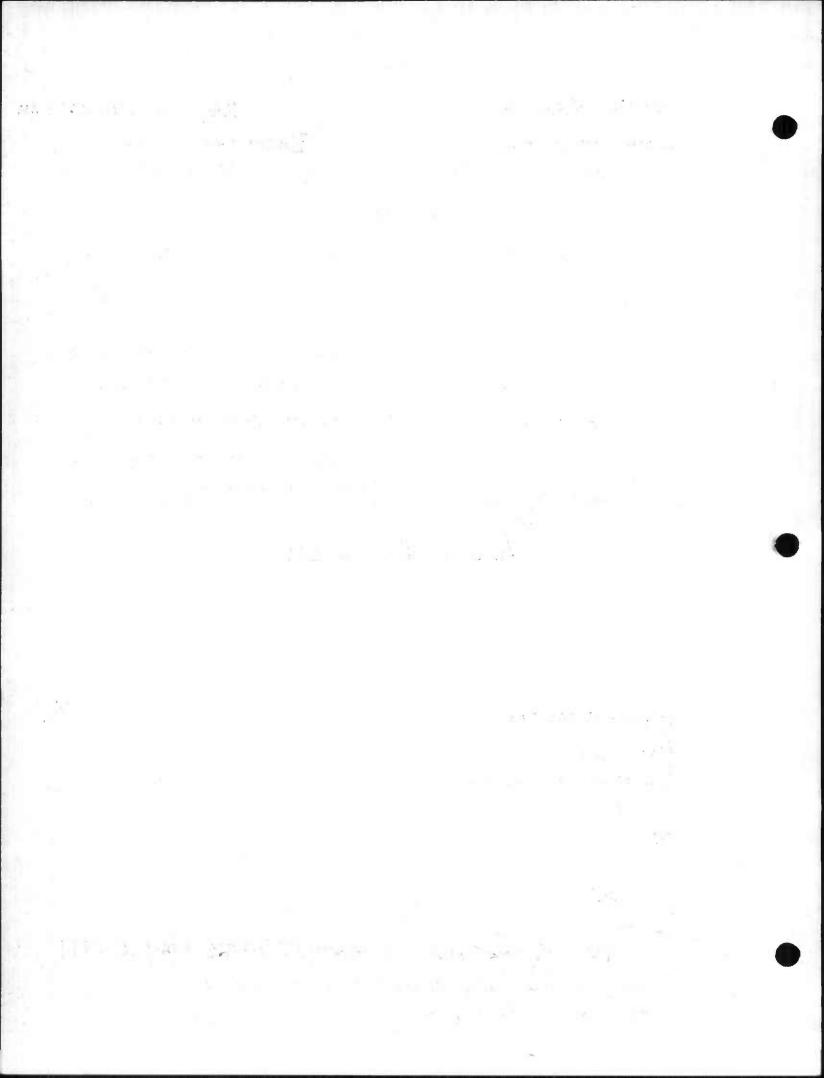
State of Maryland / Department of Health and Mental Hygiene 14698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ANOH KRAVITZ 10 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOSPITAL RATIMORE
If Under 24 Hrs. 8. Data of Bi N/A 1441L 5. Social Security Number If Under 1 Year Data of Birth Aorth, Day Year 1905 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 M 2 XX 91 Yrs. Director 215-01-4844 Usual Residenca of Decedent the Marylend 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yas 2 No N/A BALTIMORE MD Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò USA items 23s 4001 CLARKS LANE APT. 513 21215 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give XX Year or Dates: Baltimore, Maryland 21215-0020 ŏ 1 ☐ Yes 2 ☑ Xio þ Specify: WHITE 3 ₩idowed 4 □ Divorced "natural", Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) HECHT'S DEPT. STORE 12 SALESLADY 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be to Depertment of Heaith and Mental Important: If Item 27 Is marked or any Injury or other traumatic eve ROTHSCHILD MORRIS HANMAKER 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) MORTON EDELSTEIN (FRIEND) 108 JUDGES LANE, TOWSON, MD 21204 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 1 Denation 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-12-1997 BALTIMORE, MD 5 Other (Specify) HEBREW FRIENDSHIP 21. Sign 22 SOL LEVINSON & BROS., INC 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208 23a. Pan'1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one can on each line. Approximate interval Between Onsat and Death **Physician** /Medical immediata Cause (Final NEW ORTIC disease or condition resulting in death) **Examiner** Due to (or as a consequenca of): Examiner certificate be executed Sequentially list conditions, if any, laading to immediata cause. Entar Undarfying Cause (Disease or Injury that initiated events resulting in death) Last end Due to (or as a consequence of) Box 68760, physicien Physician/Medical the Dua to (or as a consequenca of): 29 esn attending | The law requires that the death Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? à 3 Probably 4 Unknown 1 Yes 2 No signed b p Be Completed 24a. Was en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? page 2 s TAILURE ENAL certificate 2000 1 ☐ Yas 2 ☐ No of Vital dlng Physician: 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 200 No 1 Yes this ne funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Division After Natural 5 Panding Investigation death 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be detarmined 28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hosp within 24 hours To the Funeral completely filed Certifying Physician: To tha best of my knowledga, daath occurred at the time, data and place, and dua to the cause(s) and mannar as stated.

2 Madicat Examinar: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and menner stated. 29a. Cartifiar (Check only one) 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) W w 30. Name and addrass of person who death (Item 23a) (Type, Print) 2401 W. BELVEDERE ANE; BALTIMORE, MD 21215 MICHAEL ZANG, 22. Registrar's Signature 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

MAY 1 4 1997



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77 is marked off r fraumatic ever To Be	Daniel E. King 19a. Informant's Neme/Reletions		16a. Decedent's Usuel Occupation (Give kind of work done during most of working			ing	16b. Kind of Businass/Industry Aero Space		ustry	
27 is me r fraums					18. Mother's Nam		laiden Suman	na)		
	Nancy King	(WIFE)		illing Address (Street Hydroplane						
tant: If Nem jury or othe	20a. Method of Disposition 1 Burial 2 Cremetion 4 Donation 5 Other (S		cematary, ca	position (Name of rematory or other place int. Cremator)		Date 20c. Location - City or Town, S Baltimore , M				
	21. Signature of Edheral Sortice	Licens	del.	22 Neme end Addre Bruzdzing	ss of Facility Ski Funer Eastern			Ма	21221	
physician and is the burial-transit edical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Last	e. Meh b. CA c	Due to (or es e cons Due to (or es e cons	lequence of):	el				4 4B.	
signed by the attending d be detached for use a d be detached for use a d by Physician/M	Pert II. Other elgnificant condition	ons contributing to death t	out not resulting in the	underlying ceuse giv	ven in Pert I.				the causs of death?	
2 shoul						24a. Was en perform	eutopsy ed?	sva	re eutopsy findings llable prior to apletion of ceuse eath?	
.9 .	25. Wes case referred to medical	I T			26. Plece of Deet	1 Ye		1 🗆	Yes 2 No	
this ceral direction of the ceral direction o	exeminer? 1 Yes 2 No	Hospital: 1 ☐ Inpati		ient 3 DOA Oth	er: 4 Nursing Ho	ma 5 Rasider	nca 8 🗆 Oth	er (Specify,		
After funer	27. Manner of Deeth 1 Naturel 5 Pendin 2 Accident investig 3 Suicide 6 Could	getion not be	28b. Time Injury	M 1 🗆	y et k? Yes 2 □ No	28d. Describe hor			Route Number	
3 4 = _	4 Homicide 29a. Certifier 1 Certifyin	building, et building, et g Phyelclan: To the best Examinar: On the basis o	of my knowledge, dea	eth occurred et the tin	ne, dete end plece,	City or Town,	State)	enner as ate	eted.	
	29b. Signeture end title of certifier	end menner st	eted.	29c. Licans	18487	29	d. Dete signe	d (Month, D	Day, Year)	
70 30	30. Name and address of parson MYO THA	who completed ceuse of a	deeth (Item 23e) (Type	e, Print)	DRIVE,	STE 20	6,BA	(70, A	1721237	



			State	n iviaryia		tificate of	Death		gierie Reg. No.	97	14700		
Physic /Med		Decedant's Name (First, Mide MARY	dla, Last)	KA	TUSZ			2. Data of De Month	Day	Year 1997	3. Tima of Death		
Exam		4a. Facility Nama (If not instituti Stella Maris		mber)			4b. City, Town, or Towson	Location of Daeth		y of Daath ltimo	re		
Funera Director		5. Social Security Number 184 → 12 → 1754 Usual Rasidance of Dacedant	6. Sax 1□ M 2 1 F	7. Age (In yrs	i. lest birthday) Yrs.	If Under 1 Yeer Months Deys			y, Year) 1924	9. Birthpla Countr Penny	aca (State or Foreign Sylvania		
yeard how Lat		10a. State 10b. County 10c. City, Town or Location								100	d. Insida City Limits		
ith the Marylar or 28a-f show	ector		altimore				dalk				1 ☐ Yas 2 ☐XNo		
with a	Dir	10e. Street and Number 3402 Loganvic	ew Drive			10f. Zip Coda	1222		10g. Citizan of United				
HIB	by Funeral Directo	11. Maritei Stetus 1 Nevar Married 2 Ma 3/2 Widowad 4 Divorce	12. Was Dec Armed Fo rried 1 Yas	va		13. Was Dacedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 1 □ Yas 2 ▼ No Specify: 14. Race - American Indias Bleck, Whita, atc. Specify: White					n Indian, tc.		
See Asses		15. Deceda	nt's Education ast grada completed)	, , , , , , , , , , , , , , , , , , , ,	16a. Deced	ant's Usual Occup	pation	orkina	16b. Kind of Businass/Industry				
2121 od within gjene. er than	Completed	Elamantary/Secondary (0-12)		Collaga (1-4or 5+) Beautician				Cosmetology					
Maryland d 2 should be fite th and Mental Hy 7 is marked othe	Be	17. Fathar's Nama (First, Middle Peter McLaugh	*				18. Mothar's Na	ma (First, Middle,	Maldan Sumar	na)			
aryla should nd Med marks marks	2	19a. Informant's Name/Ralation			19b. Mailin	g Addrass (Straat			Routa Number, City or Town, Stata, Zip Coda)				
nore, ages 1 an at of Heat if Rem 2 or other	Mary Lou Seagle/Daughter 3402 Loganview Drive Dundalk, Maryla 20a. Mathod of Disposition All Burial 2 Cramation 3 Removal from Stata 20b. Placa of Disposition (Nama of cemalary, cramatory or other place)									land City or Tow	21222 m, Steta		
Balltin permit. Pa Department Important anny injury ance.		21. Signatura of Funaral Sarvice Licensea Johny Louis Sacred Ht. 60 Jesus Cem. 5/13/1997 Dundal 22. Name and Address of Facility ral Home of Dundalk 7922 Wise Ave. Dundalk, Maryland											
Physician /Medical Examiner	Examiner	Immediata Causa (Final diseesa or condition resulting in death)	a. ENJ		or es a consaq		DISEA	SE			Approximate ntarval Batwean Onsat and Death		
. BOX 68/60, death certificate be executed a attending physicien end id for use as the buriel-transit	edical	Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disaasa or Injury that Initiated evants resulting in daath) Lest	c		or as a consequ								
Geath certification of for use as	Physician/M	Part II. Other significant conditi	ons contributing to de	eath but not ra	sulting in the un	darlying cause ob	van in Part I	23b. Did 1	obacco usa co	ntribute to t	the cause of death?		
P.O. hat the diby the detache	by Phys	CONGESTIN				URE	rail at Faitt.		Did tobacco uss contributa to the cause 1 Yes 2 No 3 Probably 4				
Hec Blaw has t	Completed							perfo	an autopsy rmad?	avail com of da	a autopsy findings labla prior to plation of causa aath?		
roltal I	Be Co	25. Was case referred to medical	al				26. Place of De	ath (Check only o	~	10	Yas 2□ No		
	2	axaminar? 1 Yas 2X No 27. Mannar of Death 1 Natural 5 Pandi 2 Accidant Invest	28e. Data	-	ER/Outpatient 28b. Tima of Injury	28c. fnjur Wor	4 □ Nursing I	Homa 5 ☐ Rasid 28d. Dascribe h			HOSPICE		
UIVISION tal or Attending rs after death. al Director: After	Certification:	3 Suicida 6 Could 4 Homlcida datarr	ninad 288. Place	of Injury - At h ng, atc. <i>(Sp</i> ac <i>i</i>	noma, farm, stra	at, factory, office		28f. Location (S City or Tow		per or Rural I	Route Number,		
To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	29a. Cartifiar (Check only one) 29a. Cartifiar (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.								causa(s) and madata and place,	annar as stat and dua to t	ed. na cause(s)		
To the To the comple	Σ	29b. Signature end titla of certifie	20 2	llenc	29c. Licens	564=	3	29d. Data signe	d (Month, De	y, Year)			
(Vit)		30. Nama and address of person DR. KENDALL E				rint) VALLEY RI	D. TOWS	ON, MD 21	1204		1		
Sta Regist		31. Data filad (Month, Day, Year, MAY 1 4 100		egistrar's Sign	atura	٠							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month DOROTHY KAMM 1997 6.55 AM MAY 10 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death HARBOR HOSPITAL (ENTEX BALTIMORE N/A If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5 Social Security Number If Undar 1 Year 6 Sav 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) Days 1 □ M 2120 F 212 09 8858 Yrs. 86 Jan. 30, 1911 Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2X No Anne Arundel Pasadena 10f. Zip Coda 10g, Citizan of What Country?

Funeral Director r 28a-f show Director ò must be 238 Funeral 8 þ Be altimore, Marylap 2 Department of Health important: if Item 27

Physician

/Medical

Examiner

Physician /Medical Examiner

-transit

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attending |

signed by d

peeu page 2

certificate

and

The law requires that the death certificate be executed

P.O. Box 68760

Records,

Division of Vital

Physician/Medical þ Completed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 10 Certification: Medical

29a. Cartifiai (Check only one)

29b. Signatura and titla of certifia

SAN GEETHA

31. Data filed (Month, Day, Year) MAY 1 4 3

Usual Rasidenca of Decedan 10a State Maryland 10e. Street and Number 8431 Hall Road 21122 U.S. 11 Maritai Status 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 🛣 No If Yas, Giva Yaar or Datas: 1 □ Navar Marriad 2 □ Marriad 1 Yas 2 X No Specify: Specify: 3√ Widowad 4 Divorced White 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grade completed) 16b. Kind of Businass/Industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) Board of Education 6th Maintenance 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Twist Carrie Geiselman Henry 19a. Informant's Name/Ratationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Kamm 304 Beech Grove Court Millersville, Maryland 21108 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Loudon Park Cemetery 5/13/97 Baltimore, Maryland 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final SEPSIS DAYC disease or condition resulting in death) Dua to (or as a consequanca of): 7DAYS. DIVERTICULITIS Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting In daath) Last Dua to (or as a consaquance of): MALNUTRITION Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformad? 2- No 1 Yas 2 No 25. Was casa rafarrad to madical axaminar? 26. Placa of Daath (Chack only ona) 1 Yas 2 No Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Thpatiant 2 ER/Outpatient 3 DOA 28a. Data of injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Naturai 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 ☐ Suicida 6 Could not be 281. Location (Streat and Number or Rural Routa Numbar, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida

1 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Madical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar statad.

29c. Licansa number

AS 2441614 - 34.

29d. Data signed (Month, Day, Year)

MAY

10,

1997

2/225

State Registrar



HOUSE OFFICER

30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print)



THE RESERVEN

JOHN KALISTER
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene.

Physician Motion Date Service (in matchion, plus served and number) 4e. Facility Name (if not institution, plus served and number) 5e. Social Servicy Number Cenessis Eldercare – Hammonds Lane 5. Social Servicy Number 214 14 8592 124 14 8592 125 214 14 8592 125 214 14 8592 125 215 214 14 8592 125 215 214 14 8592 125 215 215 215 215 215 215 215 215 215			Decedent's Neme (First, Middle, L.	ist)		00/1	ificate of	Death	2. Dete of 0	Reg. No.		3. Time of Death
Genesis Eldercare - Hammonds Lane 5. Secoid Security Number 214 14 8592 10 M 2 F 75 yrs. 10 Under 1 Year 10 Under 2 Hrs. 10 Unde		al			Tames I	Kalis	ter Sr		Month May	9 1	Year 997	1:10 P.M
Usual Residence of Decedent 100. City, Town or Location 101. Inside 105. State 106. County 105. Electronic 105. Electronic 105. State 105. County 105. Electronic 105. Ele	Examine	er		Carried Aller	onds La	ane					_	el
Too. State Too. County Too. County Too. City, Town or Location Too. City Town or Location Town o			214 14 8592						rs. 8. Data of E n. (Month, I April	Birth (Day, Year) 19,1922	9. Birthpleca Country) 9,1922 Maryl	
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20a. Method of Disposition 1 Spurial 2 (Coremation 3 Removel trom State 4 Denation 5 Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 25a. Part Letter the disease, or semiglications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, mindred by the semiglical bases of conditions, or heart failure. Let sub one cause on each line. 25a. Part Letter the disease, or semiglications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, mindred by the semiglication of the cause of th	2 shot and A la mar		19a. Informent's Name/Relationship	Type, Print)	19							
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Physician Medical Examiner Page 1			4001 Ritchie Highway Baltimore,									
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of cartifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	Hospita 24 hours Funeral		Check only 2 Medical Exam	niner: On the basis of	examination er	e, deeth o	ccurred et tha t stigetion, in my	time, date end ple opinion, death oc	ce, end due to th curred et the time	e ceuse(s) end me e, date end plece,	enner es stete and due to th	ed. e cause(s)

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State 31. Date tiled (Month, Dey, Year)

32 Registrar's Signature

ARC.

3927, ANNAPOLIS LA 21227



man or an armine to the same

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 9:07AM JOSEPH WILLIAM KRAMER MAY /Medicai 4e. Fecility Neme (If not institution, give street end number 4b. City, Town, or Location of Deeth Examiner 4c. County of Death HARBOR HOSPITAL CENTER N/A BALTIMORE If Under 24 Hrs. Hours Min. Min. (Month, Day, Yeer)
March 26,1961 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year Birthpiece (State or Foreign Country)
 Maryland **Funeral** 1 X M 2 □ F Months Deys 214 78 9925 Yrs. Director 36 Usuel Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 X No Anne Arundel Baltimore 28a-f 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? s 23a or must be 940 - 1st Street 21225 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 5 No if Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Meritei Stetus vurs after 1 Never Married 2 Married 6 1 ☐ Yes 2 XNo Specify: py 3 Widowed 4 Divorced Specify: White Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11th Truck Driver Trucking Company 17. Fether's Neme (First, Middle, Last) Be 18. Mother's Name (First, Middle, Meiden Sumame) Jeanette Voelker Charles Leo Kramer 2 19a. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Pages 1 and 2 f Health i Jeanette Kramer Mother 6866 Balto. & Annapolis Blvd. Linthicum, Md. 21090 altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e, Method of Disposition 20c. Location - City or Town, Stete 1 Burlei 2 Cremetion 3 Removel from Stete Department II Important: If any injury or 5/15/97 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signeture of Funerei Service Licensee 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Pgd1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Physician Immediete Cause (Final diseese or condition resulting in deeth) /Medical MENINGITIS 2 WEEKS **Examiner** Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): P.O. Pert ii. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown END STAGE RENAL DISEASE Records, þ Completed 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes an eutopsy performed? HYPER TENSION DIABETES MELLITUS 20 No 1 Tyes 2FiNo Division of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 ⊠Inpatient 2 □ ER/Outpatient 3 □ DOA 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Menner of Deeth 28a. Dete of injury (Month, Dey Year) 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred Certification: After t 1 Neturel 5 Pending Investigation death. 1 Yes 2 No within 24 hours after death To the Funeral Director: A completaly filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital Medical 29a, Certifier 112 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. \$ 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) AS2441614-40 Warram 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Taral 6 1-22 200 However St, Baltimore, MD 32. Registrer's Signeture

State Registrar 31. Dete filed (Month, Day, Year) MAY 1 4 1997

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(HW)

MAY 1997 - 1997

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_		larylario		ficate of	Death		Reg. No.	7	4704		
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the Maryla 28s-f sho notified at	Director	MARYLAND BALTI	MORE	PAI	RKVILLE				1 ☐ Yas 2X N				
5 6 5	吉	10e. Street and Number				10f, Zip Code			10g. Citizan of What Country?				
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VVIII)	Completed	15. Decedant's E (Specify only highest gi	ede completed) Collaga (1-4or	5+)	(Give kin life. DO	t's Usual Occup d of work done NOT use retired	petion during most of wor d)	rking			stry		
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Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic even	2	19a. Informent's Name/Relationship			10h Mailina /	ddraee (Ctraat	and Number or Ru		has City as Taura	Ctata Tin C	ada)		
n Mar and 2 sh sellth and n 27 is m wer traum		THOMAS LEHMAN		SON						, Stele, Zip Cc	000)		
of Health i	}	20e. Mathod of Disposition				E COURT on (Name of ory or other pled		LLE, MD	21234 20c. Location	- City or Town	State		
Dattimore, permit. Pages 1 ar Department of Hea Important: If Item 2 any injury or other 9056.		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special Control of Cont	(b)		TRO CRE	MATORY,	INC.	5/13/97		SVILLE,			
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Aftar t	iio	27. Manner of Death 1 □ Netural 5 □ Pending	28a. Data of Inju (Month, Da	iry Year) 2	8b. Time of Injury	28c. Injur		28d. Dascribe	how Injury occur	rred			
or Attending Physics of or Attending Physics of Director: After this in by the funeral di	Certification:	2 Accident 3 Sulcide 6 Could not be determined	28e. Piece of In	jury - At hom ic. (Specify)			Yes 2 ØNo		(Street end Numi own, State)	ber or Rural R	loute Number,		
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				State	oi Maryi		ertificate of		wentai Hy	Reg. No.	97	14705
	Physici	an	1. Decedent's Nama (First, Mic						2. Deta of De Month	eath Day	Yaar	3. Tima of Death
	/Medi		_	h LaPagl		•			May	10	1997	4:45 P.M.
3	Examir		4a. Facility Nama (If not institut	ion, <i>gi</i> va street and	number)			4b. City, Town, or	Location of Deat	h 4c. County	of Death	
			Sinai Hospi					Baltimor			N/A	
	Funeral Director		5. Social Security Number 218-12-7021	6. Sex X ☐ M 2☐ I		rs. last birthday, Yrs.	Months Days		8. Data of Bir (Month, Di		9. Birthple Countr Delaw	aca (Stata or Foreign ry) Vare
	D. Ru		Usual Rasidance of Decadant 10a. Stata 10b. Coun	ty	10c.	City, Town or L	ocation				10	d. Insida City Limits
	the Maryla 28s-f show notified at	tor	Maryland Bal	timore		Tows	:On					1 ☐ Yas 2 ☑ No
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2 Pate of Death 3. Time of Death **Physician** lay /Medical 4c. County of Dan 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deat Examiner CITY BAVVIEW BALTIMERE JOHNS HOPKINS 7. Age (In yrs. last birthday) H Under 1 Yaar If Under 24 Hrs. 8. Months Days Hours Min. 5. Sociel Security Number 6. Sex 9. Birthplece (Stata or Foreign Country) **Funeral** 1□M 2**X**F Days Hours 214-30-6750 86 Yrs. Director Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. fqside City Limits item 27 is marked other than "natural", or frems 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at MD BALTIMORE Director 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? ELRINO STREET 21224 U.S.A 1612 Funeral permit. Pages 1 and 2 should be filed within 72 hours efter death 1 Depertment of Health and Mantal Hygiene. Important: If Near Z7 is marked other than "natural; or Items 23. any Injury or other traumatic avant, the Mede 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) OWN HOME HOUSE WIFE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Be CONCETTINA NICHOLAS LOMBARDI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) MARCO MINNIE 1612 SI ELRINO ST. 21224 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burlal 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) BALTIMORE, 5/13 21. Signator of Funeral Service Licensee 6224 EASTERN luabeth AVE BALTO MID 23a. Part1. Enje the disease, or complications that ceused the deeth. Do not entar tha mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner signed by the ettending physician and d be detached for use as the burial-transit Sequentially list conditions, if any, leeding to Immediate ceuse. Entar Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last P.O. Box 68760, Physiclan/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Division of Vital Records. page 2 should b Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? After this certificata hes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Deeth (Chack only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 1 Inpatient 2 DER/Outpatient 3□ DOA the funeral 28e. Dete of Injury (Month, Day Yaar) of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Vatural 5 Pending Investigation deeth. 1 Yes 2 No 2 Accident within 24 hours after deeth To the Funeral Director: complately filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At home, farm, street, factory, office bullding, efc. (Specify) 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and menner as steted. Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data sigged (Month, Day, Year)

State Registrar

31. Dete filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene (

14708 Item16b 5-14-97 FilmG747 W.H.Per F/H Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Deeth 2. Data of Deeth 1997 Physician SARA 4:15 AM MOSS MAY /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death BALTIMORE 4c. County of Death Examiner LEVINDALE 7. Age (In yrs. lest birthdey) If Undar 1 Yaar If Undar 24 Hrs. Months Deys Hours Min. 5. Social Security Number 084-34-4041 8. Dete of Birth (Month, Dey, Year) 9. Birthpleca (Steta or Fore. Country) CCT. 27, 1905 SOUTH AFRICA 6. Sex 9. Birthpleca (Steta or Foreign **Funeral** 1 M 2 TE Yrs. Director Usuel Residance of Decedent with the Maryland 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MARYLAND N/A BALTIMORE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 CLUB ROAD 21210 USA death 12. Wes Decedant Evar In U,S. Armed Forces? 1 ☐ Yas 2 X Yo If Yes, Give Yeer or Detes: Wes Dacedant of Hispanic OrIgin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indien, Black, Whita, etc. 11. Maritai Status Pages 1 and 2 should be filed within 72 hours effernent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or ite 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: à Specify: 3 Widowed 4 □ Divorced WHITE 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Store Collega (1-4or 5+) Elementery/Secondary (0-12) BLOOMINGDALE"S DEPT. STC SALESWOMAN 12 17. Fether's Neme /First Middle Last) 18. Mother's Neme (First, Middle, Melden Sumama) **JACOB** SKAIST TAUBE COTZEN MAX 19e. Informent's Name/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MRS. NANCY M. LUCAS (DAUGHTER) 6 CLUB ROAD BALTIMORE, MD 21210 other 1 20b. Plece of Disposition (Name of cometery, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 6 permit. Page Department of Important: If any Injury or once. HILLTOP SERVICE CORP -5-12-1997 TOWSON, MD 21. Signature of Egneral Service Licensee 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or hear feilura. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel DEHYPRATION disease or condition resulting in deeth) Examiner Due to (or as e consequence of): YRS DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): and P.O. Box 68760. physician Physician/Medical 皇 Due to (or es e consequence of): 20 attending ; for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Onknown GASTROINTESTINAL BIREding Division of Vital Records, 24b. Were autopsy findings available prior to Completed 24e. Wes en eutopsy completion of cause of death? NIA 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate 25. Wes casa referred to medical 88 26. Piace of Deeth (Check only one) examiner Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 켵 28c. Injury et Work? 27. Mennar of Death 28e. Dete of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred After 5 Pending investigetion 1 Neturel 1 Yas 2 No 2 Accident 6 Could not be determined 3 Sulcida 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, straet, fectory, office bullding, etc. (Specify) 4 ☐ Homicide edical 29a, Certifier Certifying Phyelcien: To the best of my knowledge, death occurred at the time, dete end piece, and due to the cause(s) and menner es stated.

Madicat Examiner: On the basis of examinetion end/or invastigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end menner stated. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 20voster 30. Neme and eddress of person who completed cause of deeth (Item 2014) (Type, Print) Belvidere Balt, MD 21215 MINABNER ATTHEW 2434 Med (Month, Dey, Year) Y 1 4 1997 32. Registra State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth MECHALSKE Month DUISE 6.52PM 997 MAY 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A GOOD SAMARITAN HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) Days Hours 1□ M 3€ F Yrs. MARYLAND 80 8/16/16 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE TIMONIUM 10f. Zip Code 10g. Citizen of What Country? 21093 USA 52 NORTHWOOD DRIVE Was Decedent Ever In U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ➡No Specify: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) DOMESTIC HELP PRIVATE HOME 18. Mother's Name (First, Middle, Maiden Sumame)

3€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

7th GRADE 17. Father's Neme (First, Middle, Last)

FLSIE

5. Social Security Number

10a State

MARYLAND

10e. Street and Number

212-32-0899 Usual Residence of Decedent

Physician

/Medical

Examiner

Funeral

Director

must be notified at

тя 23а

Director

Funeral

by

Completed

Be

JOSEPH HARRY BANGE 19a. Informant's Name/Relationship (Type, Print)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

BEAN

TIMONIUM, MD

DAISY

EUGENE L. MECHALSKE, JR. 20e. Method of Disposition

52 NORTHWOOD DRIVE 20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify)

DULANEY VALLEY MEM. GAR. 5/10/97

COCKEYSVILLE, MD

21. Signeture of Funeral Service Licensee

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

22. Name and Address of Facility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD.

Immediete Ceuse (Final

VENTRICULAR TACHYCARDIA

10 MIN

disease or condition resulting in death)

SEPSIS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

Due to (or as a consequence of):

SON

Due to (or as a consequence of)

Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death?

26. Place of Deeth (Check only one)

1 | Yes 2 No 3 | Probably 4 | Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

25. Was case referred to medical

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 € No

1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

27. Menner of Death 5 Pending investigation 1 Netural 2 Accident

28a. Dete of Injury (Month, Day Year)

28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred

3 ☐ Suicide 4 T Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated.

29b. Signature end title of certifier

29c. License number

29d. Dele signed (Month, Day, Year)

MEDICAL DOCTOR

P09306

997

and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KWASHIE ATTIOGET THE SAMARUTAN HOSPITAL OF MARYLAND IN COPORATED

31. Date filed (Month, Day, Year)

MAY 1 4

DHMH 16 Rev 6/95

Box 68760. P.O. Division of Vital Records, The law requires that the death certificate be executed

Balltimore, Maryland

8

Pages 1 and 2 should

of Health

= 5 Department of important: If any injury or

Physician

/Medical

Examiner

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attending physician for use as the buna

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Physician/Medical

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Be Completed

2

Certification:

Medical

or Attending Physician: A S. after dea. within 24 hours a
To the Funeral C

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State

Registrar

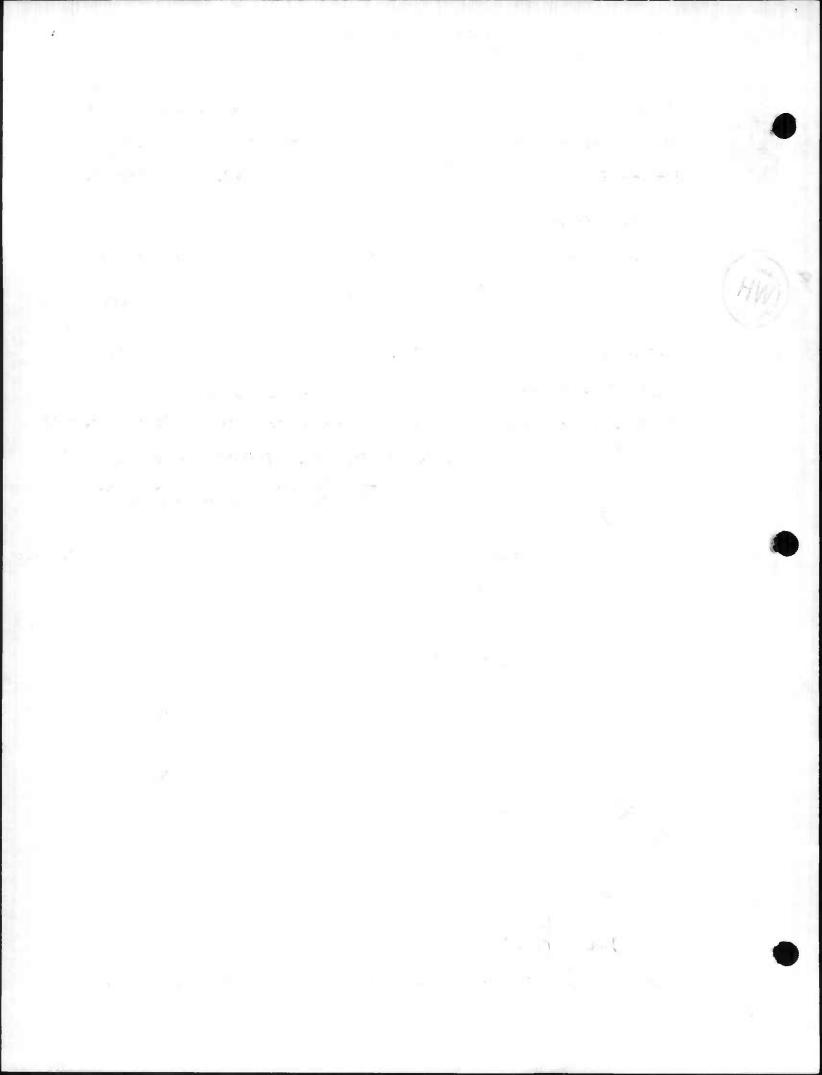
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				of Marylar			of Death		ygiene 9 Reg. No.	/ 1 %	710	
Physici	an	1. Decedent's Nama (First, Middla, I	Last)					2. Data of D Month	Day	Yaar 3.	Tima of Death	
/Medic		Bradley		MILLER			-1	May 10	- 1		:52 am	
Examin	er	4a. Facility Nama (If not institution, g		1000			•	r Location of Dee				
		Franklin Square 5. Social Security Number 6.	e Hospit	al Cent 7. Age (In yrs.		If Under 1 Y	Rosed			timore	(Cto to an English	
uneral irector		218-64-5008 Usual Rasidance of Decedant	1 X M 2□ F	38	Yrs.		ys Hours Mi	n. (Month, D	Say, Year)		Stata or Foreign	
show d.ml	پ	10a. Stata 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limit		
28a-f show notified at	Director	Maryland Baltimo	re	Ess	ex	10f. Zip Coo	da		1 ☐ Yas 2 ☐ X			
N. M.		1419 Sussex Road				21221	1		United.	States		
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er trai		Marsha S. Bonomo	Siste	r			dence Cre					
or other to		20a. Mathod of Disposition 1 □ Burial 2 □ Cremetion 3	□Ramoval from			sition (Nama o natory or other		Data		- City or Town, S		
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any		Dohnus I De	\$ 15aa		Duc 792	la-Ruck 22 Wise	ddress of Facility Funeral Avenue B	Home of altimore	Dundalk,	Inc.	2	
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To the Funeral D completely filled i	edical C	29a. Cartifiar Certifying F	Physician: To the	best of my kno	wledga, daath tion and/or Inv	occurred at th	a tima, data and pla ny opinion, daath oc	ce, and dua to the	a ceusa(s) and ma	annar as stated. and dua to tha c	euse(s)	
Fu Biel	ㅠ	one)	f and man	nar stated.								

State Registrar 31. Data filed (Month, Day, Year)

32. Ragistrar's Signatura



				larylan	Certi	ficate o	f Death			g. No. 9	/	4/11		
Physici /Medic		Decedent's Name (First, Middle, Last		erine	H. Mart	in	1	2. Date Mont May		Day	Year	:35 P.M.		
Examir	ıer	4e. Fecility Name (If not institution, give)				, or Location of	Deeth	4c. County	of Deeth			
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Funeral Director		210 10 1019	ex 7. A □M 2[X[F	ge (in yrs. i 81		If Under 1 Yea Months Dey		Min. (Mont	h, Dey, 1	(ear) 1915	9. Birthplace Country) Mary1	(Stete or Foreign		
. B.		Usual Residence of Decedent 10e. Stete 10b. County		10c. City	, Town or Locat	ion		···-			10d.	Inside City Limits		
4 sh	Po	Maryland Anne Ar	undel	Pa	sadena				1 ☐ Yes 2 🔯 [
noti	Directo	10e. Street end Number				10f. Zip Code	i		10	g. Citizen of V	Whet Country?			
						211	22		U.S.					
E III	Funeral	11. Maritel Stetus	12. Wes Deceden Armed Forces	Ever in U,	S. 13. Wa		f Hispenic Origin Iben, Mexican, F	? (Specify Yes	or No-	14. Rec	a - American I	ndien,		
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		20e. Method of Disposition	Daugittei		laca of Dispositi	Street	, Pa	sadena,			City or Town,	State		
6		1 X Buriei 2 ☐ Cremetion 3 ☐		CE	emetery, cremet	ory or other p		1						
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anus		21. Signedie of Pulleral Servica Lican	see /	1							Home P			
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d for use es the burial-transit	/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b	Due to (or	es a consequer as e consequer	nca of):	GAI	R						
deteched for u	ciar	Day II Others Later Annual Market						1			1			
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y the funeral di	Certification: To	1 Yes 2 No 27. Menner of Deeth 1 Naturai 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only) 1 No 2 No 5 Pending investigation 6 Could not be determined	28e. Dete of In (Month, D 28e. Pieca of Ir building, e vslcian: To the best	ay Year) ajury - At hore tc. (Specify) of my know of exeminati	Injury me, farm, street	M 1	Yes 2 No	28f. Local City of	or Town,	Stete)	enner as state	1.		
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is certific director,	edical Certification: To	1 Yes 2 No 27. Menner of Deeth 1 Naturai 2 Accident 3 Suicide 4 Homicide 29e. Certifier (Check only one) 29b. Signeture and title of certifier	28e. Dete of Inj (Month, D 28e. Pieca of Ir building, e visician: To the best and menner's	of my know of exeminati	Injury me, farm, street) vledge, deeth oc ion end/or inves	M 1 , factory, office courred et the ligation, in my 29c. Lice	e time, dete end propinion, death	28f. Local City of Cit	o the cautime, det	Stete) use(s) end me e end plece, d. Dete signed	enner as stated end due to the d (Month, Day	1. ceuse(s) . Year)		





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State of Maryland / Department of Health and Mental Hygiene

14712 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth **Physician** Month Dey MATHIAS, JR 12:25 PM JOHN 1997 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner ST. AGNES HOSPITAL BALTIMORE N/A 5. Sociel Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Dev. Year) Birthplece (Stete or Foreign Country) **Funeral** 1⊠M 2□F Deys Hours 68 Yrs Director 213-28-3613 DEC 23,1928 MARYLAND Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City I Imits MD BALTIMORE 1 ☐ Yes 2 ☑ No BALTIMORE 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Counfry? 4426 FENOR ROAD 21227 U.S.A. 12. Was Decedenf Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: KORE 11. Meritel Stefus 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify. KOREAN Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12TH GRADE COMPUTER OPERATOR RAILROAD 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hi ant: If Item 27 is marked off 18. Mother's Name (First, Middle, Meiden Surname) JOHN HENRY MATHIAS LILLIAN MAE BUHL 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) KATHERINE G. MATHIAS(WIFE) 4426 FENOR ROAD - BALTIMORE, MD 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State injury or Department if 4 ☐ Donetion 5 ☐ Other (Specify) WOODLAWN CEMETERY 5/13/97 BALTIMORE 21. Signeture of Fundal Service Licensee HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 er the disease, or complications that caused to death. Do not enter the mode of dying, such as cerdiac or respiretory errest, heart failure. List only one cause on each more Approximate interval Between Onset end Deeth **Physician** /Medical immediate Cause (Finel ARRHYTHMIAS VENTRICULAR DAY disease or condition resulting In death) Examiner MYUCARDIAL INFARCTION DAY Examiner ANTERIOR physician end the buriel-trens Sequentially list conditions, if eny, leeding to Immediete ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lesf Due to (or es e consequence of) Physician/Medical Due to (or es e consequence of): use signed by the a P.O. Part tl. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, p 24b. Were sutopsy findings eveileble prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? Completed 1 Yes 2 000 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes cese referred to medical exeminer? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpetient 2 □ ER/Outpatient 3 □ DOA funeral 27. Magner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Netural 5 Pending death. 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours efter death. Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours 1 Sertifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end manner es steted.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner steted. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical (Check only one) 29b. Signature end title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) PO 9143 MAY 09, 1997 m. D . 20 death (Hem 23a) (Type, Print) Agres Hespital, 900 Cater Ave, Buttinare, MD 21229 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NWE SF THI 31. Dete filed (Month, Day, Year)
MAY 1 4 1997

DHMH 16 Rev 6/95

Registrar

HW

				I / Department of H Certificate of L		ygiene Reg. No.	7 14713			
Physi /Med		1. Decedent's Nama (First, Middle, Las		Mack	2. Date of Month	Day 19	3. Time of Deeth			
Funera		Usual Rasidence of Decedent 10a. State 10b. County	Bayview H PX M 2 F 86 10c. City,	st birthday) Yrs. If Under 1 Year Months Days Town or Location		Birth Day, Year)	Birthplace (Stata or Foraign Country) Maryland 10d. inside City Limits			
MH J	Funeral Director	Md. Balti 10e. Street and Number 7240 Stratton		Eastwood 10f. Zip Code 21224	1	10g. Citizan of Wh	1 ☐ Yes 2 📉 No at Country?			
5-0020 72 hours after death natural, or items 23 scal Examinar must	by Funeral	11. Maritel Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	i. 13. Was Decedent of Hi	Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1□ Yes ※☑ No Specify: Specify: White					
2121 within ene. then	Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 10 yrs.	ucetion de completed) College (1-4or 5+)	16a. Decedent's Usuel Occupe (Give kind of work done d life. DO NOT use retired, Longshorema	uring most of working	16b. Kind of Busi				
land lid be file fental Hyg had othe	To Be C	17. Father's Name (First, Middle, Last) Conrad Mack		-	18. Mother's Name (First, Midde Cunigunda F					
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Baltimore, Maryland 2 sommit. Pages 1 and 2 ahould be filed Department of Health and Mental High important: If Hem 27 is marked other my injury or other traumetic event, I		20a. Method of Disposition 1X Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State Sacr	ace of Disposition (Name of metery, crematory or other place Ced Heart Of	Date	20c. Location - C Dundal	ity or Town, State			
Baltimo pemit. Page Department of		21. Signature of Formati Service Licent	Z	_	s of Facility Funeral Hom- lers Point R		dalk			
Physiciae /Medica Examine		23a. Park. Enter the disease, or compands, or heart faiture. List only of the second se	e. September of the control of the c	Do not enter the mode of dying			Approximate Interval Between Onset and Death 3 days 3 days			
OX 68760, certificate be axecuted inding physician and use as the bunal-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Disease or Injury that initisted events rasulting in death) Last	Due to (or a	as a consequence of):			Jacys			
Records, P.O. B. e law requires that the death has been signed by the atterned in a should be detected for	Completed by Physician/M	Part II. Other significant conditions of		ting in the underlying cause give	24a. W	as an autopsy	ibute to the cause of death? B Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?			
Vital Re licien: The la certificata ha rector, page ha	Be Co	25. Was cese referred to medical exeminer?			26. Plece of Deeth (Check onli	Yes 2 ANo	1 Yes 2 No			
Vision of Vita Attending Physician: Ir death.	Medical Certification: To	1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Dey Year)		at 28d. Descrit.	e how injury occurred	d			
Divi	Certifi	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	28f. Location City or	n (Street and Number Town, State)	or Rurel Route Number,			
Division To the Hospital or Attendi within 24 hours aftar death To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my knowl iner: On the bests of examinetic and manner stated.	tedge, death occurred at the tim on and/or investigation, in my op	e, date and place, and due to the time to the time.	ne cause(s) and manr e, date end place, an	ner as steted. d due to the ceuse(s)			
To the To the comple	Σ	29b. Signatura and title of certifiar	1	29c. License		4.4	(Month, Day, Yeer)			
15		30. Name and address of person who o		23a) (Type, Print)	118 O Easlem Aven	may 11	, 1777			
S Regis	tate trar	31. Date filed (Month, Day, Year) 7	3. Degistrar's, Signatu	-Randelle	Justan Fron					

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SPECIAL SPECIA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ANTHONY JOHN NOPPINGER **Physician** /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLESTOWN CARE CENTER BALTIMORE BALTIMORE If Under 24 Hrs. 8. Date of Birth Month, Dey, Yea 6. Sex M 2□ F If Under 1 Year Months Days 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Steta or Foreign 212-01-3169 90 Director Usual Residence of Decedent with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Medical Expression must be notified at HOWARD 1 ☐ Yes 2 No ELLICOTT Director 10f. Zip Code 10g. Citizen of What Country? 9317 RAMSEV permit. Peges 1 and 2 should be filed within 72 hours after death a Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 28a any injury or other traumatic avanta. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Nevar Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 Yes 2 No þ Specify: 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry WEART PRINTING Elementery/Secondary (0-12) Coilege (1-4or 5+) PRINTER 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) BARBARA MICHAEL NOPPINGER FOERTSCH 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CITY, MD 21042 BERNARD NOPPINGER RAMSEY DR. ELLICOTT 20b. Piaca of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 21. Signature of Funeral Service Licanses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, of feart failure. List only one cause on each lina. 21224 **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Sepsis days Examiner Due to (or as a consequenca ot) Examiner signed by the attending physician end d be detached for use as the burial-transit Sequentially list conditions, if any, leading to immadiete cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4% Unknown þ 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed peed certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Deeth 28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 1 Yas 2 No Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 \(\text{Homicide} \) Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) edical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year)

Catonsville

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

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Registrar

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31. Date tiled

May 1 4 1997

State of Maryland / Department of Health and Mental Hygiene Item10f 5-15-97 FilmG747 W.H.per F/H Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** Month 4a. Facility Name (If not institution, give street and number 17:35 mai 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore N/A If Undar 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplaca (State or Foreign Country) New York **Funeral** 1□M 257 F Days Yrs. Director 75 020-16-4196 Nov 10, Usual Residence of Deceden the Meryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1€Yes 2□No Director Pima AZ Tucson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 85712 85715 2025 N Calle de Vida U.S.A. death 12. Was Decedent Ever In U.S. Armed Forces? 1 Yes, 27 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ☐ No Specify: P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiana. Important: If Item 27 is merked other than any Injury or other traumetic avant Elementary/Secondary (0-12) College (1-4or 5+) Public Education Art Teacher 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Sirk Louis Bertha Yanofsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Jonathan D Philipson (son) 13 diamond Crest ct., Baltimore, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/13/97 Evergreen Cemetery Tucson, AZ 21. Signature of Funeral Service Licensea 22. Name and Address of Facility Sol Levinson & Bros 8900 Reisterstown Rd, Pikesville, MD 21208 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona causa on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Finel disaase or condition resulting in deeth) /Medical Pancreatitis (Necrotizing) Examiner be executed buriel-trensit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medicai the Due to (or as a consequence of) Part II. Other algoriticent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use coptribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ð 2 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? certificate hes 1 Yes 2 LNo 1 Yes 2 No Division of Vital l or Attending Physician: efter death. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Junpatient P 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred After 5 Pending investigation 1 Natural s efter death.

I Director: Aft din by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide apital (Funeral Peurs 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as atlated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) medicine P09138 Rosident 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) (Type, Print) St-Asnes Hospital 900 caton Ave. Battimore Prattie, m.D.

Registrar

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M. Shannor

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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Ralph Nelson Pierpont Sr. May 1997 11 10:12 P.M. /Medical 4e. Feclity Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 7875 Crilley Road Apt. 44 Glen Burnie Anne Arundel H Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number If Under 1 Year Months | Days 6 Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1 1 M 2 □ F Days Yrs. Director 213 36 8735 August 4,1941 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23e or 28e-f short miner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Glen Burnie Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7875 Crilley Road Apt. 44 21060 II.S. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: þ Specify: White 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondery (0-12) Cotlege (1-4or 5+) Wireman Westinghouse 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Baltimore, Maryland Be and Ments is marked Evelyn Ingram permit. Pages 1 and 2 should I Department of Health and Meni Important: If Nem 27 is market Ralph Chester Pierpont 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Davis Daughter 5314 Patrick Henry Drive Baltimore, Maryland 21225 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 5/14/97 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) New Cathedral Cemetery 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel Caremorna of Lung - Metastation diseese or condition resulting in deeth) Examiner Examiner Adenocarconon burial-transit certificata be executed Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760. Physician/Medical the Due to (or es e consequença of): signed by the a Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 10 20 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Be Completed 24e. Was en eutopsy performed? 25. Wes case referred to medical exeminar? Squamous cell Cancer certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completally filled in by the funeral director, I 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 70 1 Yes 2 1 No 27. Menne of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Evertifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end pteca, and due to the ceuse(s) end menner steted. Medical 29a. Certifier (Check only 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

Wolfe Sty Baltonne, MD

State Registrar 31. Date filed (Month, Dev. Year)

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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Registrar's Signeture

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Posey Dorothy 4130 pm 1997 mar /Medical 11 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner tacilit sider Howard when Thacete COK 5. Social Security Number if Under 1 Yeer Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Yeer) Birthplaca (State or Foraign Country) **Funeral** Months Min. Devs Hours 1 M 2 TF 68 Vrs Director 407-30-8520 MAY 15,1928 KENTUCKY Usuet Residenca of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show Director HOWARD 1 ☐ Yas 21 No ELLICOTT CITY 10e. Street end Number 10f Zin Code 10g. Citizen of Whet Country? 8 must be TIS 238 9683 OAK HILL DRIVE 21042 U.S.A. Funeral 12. Wes Dacadent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spacify Yas or Notif Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No by Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) 12TH GRADE HOMEMAKER HOMEMAKING Baltimore, Maryland 17. Fethar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be h and Mental I is marked or Pages 1 and 2 should be CLYDE RIFFE BETTY FLOYD 19e. tntorment's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) Important: If Item 27 is a say in jury or con-MAX H. POSEY (HUSBAND) 9683 OAK HILL DRIVE - ELLICOTT CITY, MD 20b. Plece of Disposition (Nema of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State Dete 5/12/97 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donetlon 5 ☐ Other (Specify) CARROLL CREMATION SERVICE HAMPSTEAD, MD 21. Signature of Funeral Service License 22. Name end Addrass of Fecility HUBBARD FUNERAL HOME INC. Erner the disease, complications that caused the death, so not enter the mode of dying, such as cardiac or raspiretory errast, ar heart feliure. List only one cause on each line. Approximate Interval Between Onsat and Deeth **Physician** Immediete Ceuse (Finel diseese or condition resulting in deeth) /Medical Examiner Examiner cancel physician and s the burial-transit that the death certificata be axecuted Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Last Due to (or es e consequence of) P.O. Box 68760, Physician/Medicai Due to (or es e consequença ot): nse signed by the a Part II. Other aigniticant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yee 2 ☐ No ON Records, by Tha law requires 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24e. Wes en autopsy performed? page 2 s cartificata 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Wes cese reterred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Shursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 3□ DOA 27. Menner of Deeth 28e. Dete of trijury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigetion 1 Naturel To the Hospital or Attendil within 24 hours aftar death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, tactory, office building, etc. (Specify) 4 Homicide Filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner steted. 29a. Certifier Medicai completely (Check only one) 29b. Signeture end title of certifier 29c. Licanse number 29d. Date signed (Month, Dey, Year)

State Registrar

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30. Name end eddress of pereon who completed cause of deeth (Item 23e) (Type, Print)

JUSSI, MD 10805 Hickory Pridge 12d Colembia MD.

Julia Maridon Pandre

Hill ,

1981 - 19

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death VINA V. PENZKOFE'R 10:15PM 4a. Facility Name (If not Institution, give street and r 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE ST. AGNES HOSPITAL 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Months Davs Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months 1 □ M 2 🖫 F Yrs. 484-14-0724 OCT. 23,1921 IOWA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD. BALTIMORE CATONSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 MAIDEN CHOICE LANE PV615 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 No Specify: Specify: WHITE 3√Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th GRADE **PHOTOGRAPHER** SELF-EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROY C. BEIL CELESTIA B. OWEN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) CAROL PLOTNICK (DAUGHTER) 604 PARK AVE. LAUREL, MD. 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION SERVICE 5-11-97 HAMPSTEAD, MD. 21. Signature of Fund Servica Licensee 22. Name and Address of Facility 4107 wilkens ave. HUBBARD FUNERAL HOME BALTO., MD. 21229 usa 23a. Part 1. Entire the disease, or complications that caused the dear D not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in death) CEREBROVASULAR ACCIDENT Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): thet initiated events resulting in deeth) Last Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown ACUTE MYOCARDIAL INFARCTION 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

Physician/Medical by Completed

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Physician

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Department of Health Important: If Item 27

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/Medical Examiner

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To the Funeral Director: After it completely filled in by the funera

Box 68760. certificate be

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altimore, Maryland 2121

Director

Funeral

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Completed

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3 ☐ Suicide

29a. Certifier

4 Homicide

27. Manner of Death

1 Natural
2 ☐ Accident 5 Pending Investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Phyaiclan: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. (Check only onel 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

BALTIMORE

NSAH, M.D. 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) D42075 MAY

AGNES HOSPITAL

NSAH EMMANUEL

31. Date filed (Month, Day, Year)

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State MAY 1 4 1997 Registrar

32. Registrar's Signature Telia Midson-Rondelle

DHMH 16 Rev 6/95

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FRANCES D. RIELLY

Items:23 part I,27 per MEO G-748 6/9/97 dh

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Records, P.O. Box 68760,		Baltimore, Maryland 21215-0020
he law requires that the death certificate be executed	Phy /N Exa	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
e has been signed by the attending physician and	ysid led am	Department of nearth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show
age 2 should be detached for use as the bunal-transit	ciá lic in	any injury or other traumatic event. The Medical Examiner must be nothing at

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State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Item5 6-12-97 FilmG748 W.H.per F/H State of Maryland / Department of Health and Mental Hygiene Item20c 5-14-97 FilmG747 W.H.Per F/H Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** ROSALIND ROSEN MMAY 100ay1997 Year 3:00 AM /Medical 4a. Facility Neme (If not institution, give street end number)
OAK COURT NURSING HOME 4b. City, Town, or Location of Death RANDALLSTOWN 4c. County of Deeth Examiner BALTIMORE 5. Social Security Number If Undar 1 Year | If Under 24 Hrs. 8. Dete of Birth Month, Day, Year 917 7. Age (In yrs. lest birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 218-10-62194 10 M REF 79 Yrs. MD Director Usuel Residence of Decedent the Maryland 10c. City, Town or Location RANDALLSTOWN 10b. County BALTIMORE 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at 1 Hes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 21133 USA 3701 WOODSPRING COURT death 12. Was Decedent Evar In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Meritel Status Pages 1 and 2 should be filed within 72 hours after of tent of Health and Mental Hygiene.

At: If Item 27 is marked other than "natural", or item 1 □ Nevar Merried 2 □ Merried 1 Yes 2 No If Yes, Give Year or Detas: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 MNp Specify: WHITE þ 3 Widowad 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOSTESS McDONALD'S 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be PURZITSKY BESSIE LEVY SOL permit. Pages 1 and 2 shoul Department of Health and Milmportant: If Item 27 is mart any Injury or other traumati 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1 WINSTEAD COURT BALTIMORE, MD 21228 SHARYN DOYLE / DAUGHTER 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetery or other plece) 20c. Location - City or Town, Stata 1 █ Buriel 2 ☐ Cramation 3 ☐ Removal from State 5-12-1997 BBALTIMORE, MD (ANSHE EMUNAH) AITZ CHAIM 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility SOL LEVINSON & BROS, INC. 21208 un 8900 REISTERSTOWN RD; PIKESVILLE, MD 23a. Pertf. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Onsat and Deeth **Physician** /Medical Immediate Cause (Final 4mphona Sev. MOJ. diseasa or condition resulting in deeth) Examiner Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Couse (Disaese or Injury that initiated events resulting in death) Lest and -fran Due to (or es e consequence of): Box 68760 physician Physician/Medical 2 Dua to (or es e consequenca of) ä guigo attor Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ħ 1 | Yes 2 | No 3 | Probably 4 Nonknown peubis þ 8 24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? 24a. Was an autopsy performed? Completed **Dege 2** 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to predical Be 28. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA

Division of Vital Records, P.O.

2 Certification:

27. Menner of Deeth

1 Waturel

2 Accident

4 - Homicide

3 Suicide

29e. Certifier (Check only one)

certificate 2 Athar death. after death Director: in th o the Hospital of thin 24 hours at the Funeral Di

Medical State Registrar

29b. Signatura and titla of certifiar

5 Pending

investigation

6 Could not be determined

28e. Dete of Injury (Month, Dey Year)

29c. Licansa number

28c. Injury et Work?

1 Yes 2 No

28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steled.
2 Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner steled. 29d. Data signed (Month, Day, Year)

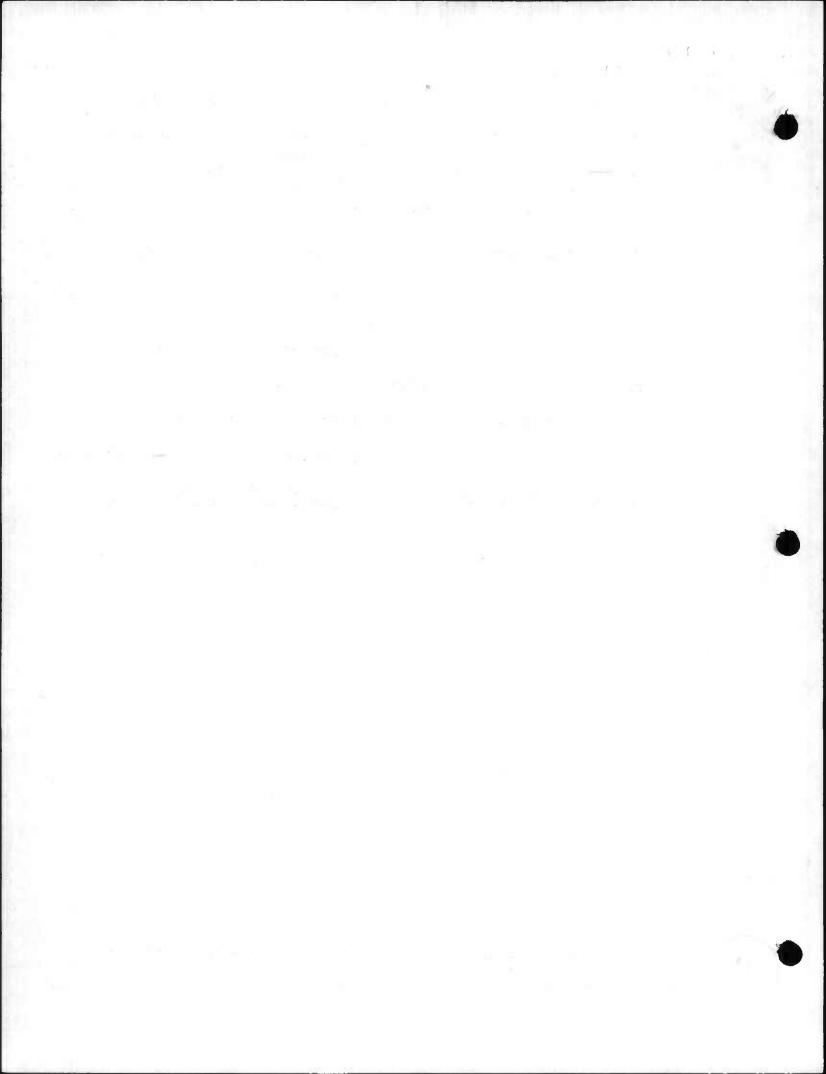
28f. Location (Street end Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

008029

30. Name end edowss of person who completed pause of deeth (Item 23e) (Type, Print)

MARGOLIS M.P. 70 F. Partys Mill Rd- Ow wes Mill My. Stephen 31. Dete filed (Month, Day, Year) while Davidson



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item4c 5-14-97 FilmG747 W.H.Per F/H Items: 7.8 per F.H. G-747 5/29/97 reb Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** Esther L. Koscustock 1997 1:00 AM Mai /Medical 4b. City, Town, or Location of Deeth 4e. Facility Nema (If not institution, give street end number) 4c. County of Death Examiner Baltimore Baltimor Hospital Sihal If Under 24 Hrs. 8. Date of Birth 1911 9. Birthplace (State or Foraign Country) If Under 1 Year 5. Sociel Security Number 7. Aga (In yrs. last birthday) **Funeral** Days 1□ M XXF Months 220-20-5842A Director 86 JAN. 26, 1913 Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exeminer must be nothed at Director 1 Yes 2 No MD N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7121 PARK HEIGHTS AVE. #301 21215 U.S.A. Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. hours after ☐ Yes 2 No f Yes, Give 1 ☐ Navar Married 2 ☑ Marriad altimore, Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: þ WHITE 3 Widowad 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry filed within 7 I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) **HOMEMAKER** OWN HOME marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be permit. Pages 1 and 2 should be to Department of Health and Mental important: If Item 27 is marked of any injury or other treumatic sve HYMAN LUBITCH GUSSIE WEINSTEIN 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JUDY HYMAN / DAUGHTER 7121 PARK HEIGHTS AVE #301 BALTIMORE, MD 21215 20b. Plece of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other plece) 1 Buriai 2 ☐ Cramation 3 ☐ Removal from State 4 Donation 5 Other (Specify) BETH TFILOH 5/12/97 BALTIMORE, MD uneral Service Ma 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208 23a. Peri1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haert feilure. List only one cach line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner Mitral stenosis physician and s the burial-transit certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in daath) Last Due to (or es e consequenca of) P.O. Box 68760, Physician/Medical Due to (or as a consequence of) use as for u Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? by the detached 1 Yes 25 No 3 Probably 4 Unknown signed t Records, by 24a. Was an eutopsy performed? 24b. Were autopsy findings available prior to Completed peen completion of cause of deeth? page 2 12 No certificate 1 Yes 1 ☐ Yes 2 No on of Vital iding Physician: Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Aftar Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es steted. Medical E er: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the causa(s) and manner stated. To the 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) hay MD AS-2402321-DS-9034 who completes cause of deeth (Item 23a) (Type, Print) 30. Name end eddress of person

Hospital

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32. Registrar's Signetura

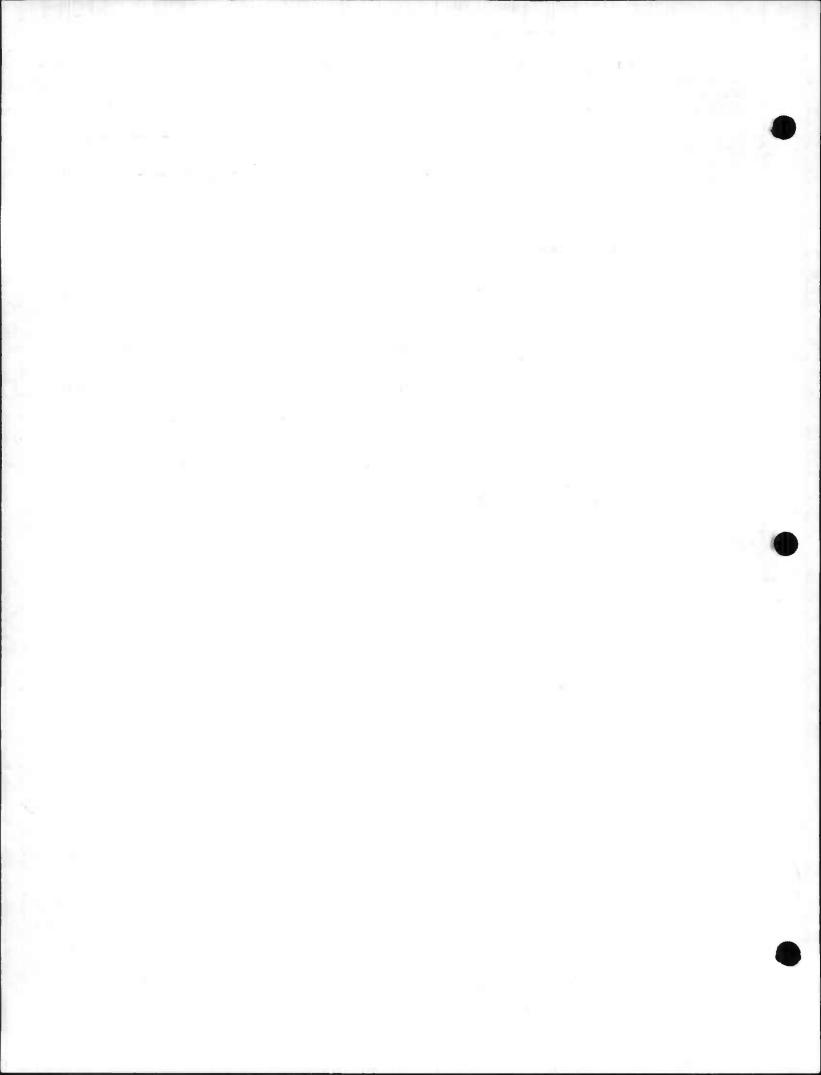
DHMH 16 Rev 6/95

State Registrar Danny

31. Date filed (Month, Day, Year)

1 4 1997

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	_				Ce	ertificate of	Death	F	leg. No.	1	14/23
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Examir		4a. Facility Nama (If not instituti	on, give streat and numi	ber)			4b. City, Town, or L	ocation of Death	4c. County	of Deeth	
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Funeral Director		5. Social Security Number 246–38–9081	6. Sex 7 1 1 M 2 □ F	. Aga (In yrs. 67	last birthday Yrs.	Months Days		8. Date of Birth (Month, Day July 8,	1929	9. Birthpi Coun orth	olaca (Stata or Foreign otry) Carolina
pu »		Usual Residence of Decedent 10a. State 10b. Count	v	10c Ci	ty, Town or L	ocation					
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HVB	by	1 ☐ Never Marriad 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	Was Give	No		If Yes, specify Cul 1☐ Yes 2☐No	pen, Mexican, Puerto Specify:	Rican, etc.)		k, White, a	
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Dre.		20a. Method of Disposition			Placa of Disp	osition (Neme of ematory or other pla	200)	Date	20c. Location -	City or To	wn, Stata
Baltimore, eemil. Pages 1 ar Separtment of Hea moortant. If Item : my injury or other title.		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (are			Park 5/1	2/1997 F	Baltimor	e. C	'o. Md.
alt.	Î	21. Signature of Funaral Service	Licensee /	0	2	2. Nama and Addr	ess of Facility			0, 0	
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		23a Part 1 Enter the disease, of heart failure. Lis	or complications thet cau	sed the deat	h. Do not en	ter tha moda of dy	Eastern A ing, such as cardiac	or raspiratory arr	ssex, Mo	21	Approximate
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/Medical		Immediate Cause (Finel disaase or condition	ma	tac-	fatir	05001	nageal	CAMO	05		6 months
Examiner		resulting in death)	e. 14(E		or as e conse		ting e in e	01/1/0	CT		6 morning
D #	iner			•		,					
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x 68760, ertificete be execut fing physician and e as the bunel-tra	<u>m</u>	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury									
87 Cete I Chysi	edicai	that initieted events resulting in death) Last	Ü	Due to (o	r es a conse	quanca of):					
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P.O. BO.	Physician										
O. the de dy the ached	ysi	Part II. Other significant conditi	ona contributing to deat	h but not ras	ulting in the u	inderlying causa gi	ven in Part f.	23b. Did to	bacco uae con	iribute to	the cause of death?
requires that the								1 🗆 Y	8 2□ No	3 Prob	Dably 4 Unknown
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cord w require been si should	ete							perform		ava	nileble prior to ripletion of causa
I Rec	Completed										death?
f Vital Rystelan: The last certificate he director, page	ပိ	25. Was case referred to medica	N .					1 \(\text{Y} \)		1	Yes 2 No
of Vita Physician: this certific	o B	examiner?	Hospital:			- Ot	26. Plece of Deat				11
Phys rthis	-	27. Manner of Death	1 □ Inp		ER/Outpatie 28b. Time o	III JUDA	4 LI Nursing Ho	me 5 Reside		1 / 2/	Hospice
Division or Attending I efter death. Director: After	to	1 Neturel 5 Pendi 2 Accident Invest		Day Year)	Injury	Wo	rk?]Yes 2 □ No	200, 0 000,100 110	, w inquity occurre		V
Divisio	fica	3 Suicide 6 Could	not be	Injury - At ho	ome, ferm, st			28f. Location (St	reet and Numbe	r or Rural	Route Number
Div efter	Certification:	4 Homicide	building,	etc. (Specifi	()	reet, fectory, offica		City or Town	, Stete)		riodic riamon,
spita hours neral y fille		29e. Certifier Certifyli	ng Physician: To the be	st of my kno	wledge, deet	h occurred at the ti	me, date and place,	end due to the ca	use(s) and mar	ner es sto	eted.
Division o To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After thi completely filled in by the funeral	edicai	(Check only 2 Medical one)	Examiner: On the basis and manner	s of examinal	tion end/or in	vestigetion, In my	opinion, deeth occurr	ed at the time, da	ate and place, a	nd due to	the cause(s)
To the To the Complex		29b. Signature and time of conflic	or 1	1-0		29c. Licens	se number	25	9d. Date signed	(Month, E	Day, Year)
		1. Hm	Thornilla	Vo.	uns	12	CANS		MAN	9,	1997
6	-	30. Name and addrass of person	who completed cause of	of death fiter	23a) (Type,	Print)	300-		1	1	- /
ン		W.A.R	:144 G	Bm	- 6	701 N.	Charles	St. Br	Ito 1	nd	21204
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State of Maryland / Department of Health and Mental Hygiene

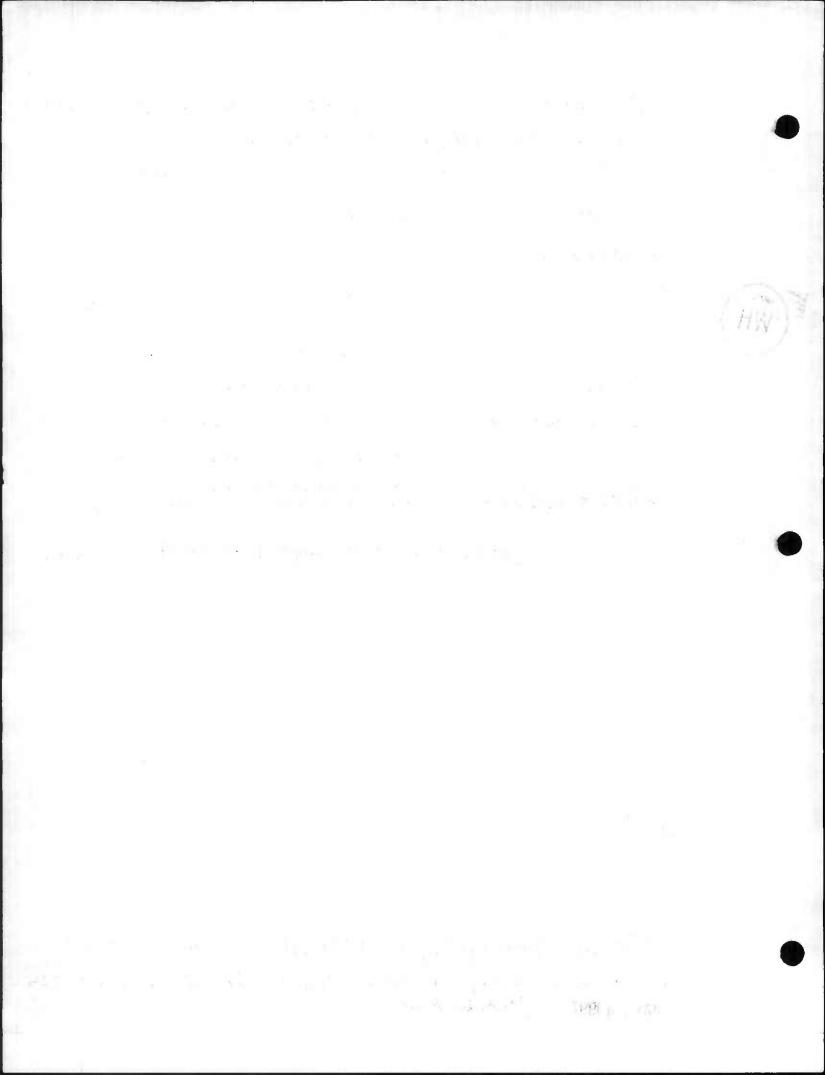
14724 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RUGGIERO ANGELO MAY 10:10 pm 1997 /Medical 4a. Fecility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** medical Center Baltimore Hospital Harbor If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F 212-76-9630 Director MARCH 11,1920 Usual Residence of Decedent 10e. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits MD N/A BALTIMORE Director Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b must be ms 23a 3025 MARDEL AVENUE 21230 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) NEVER WORKED N/A N/A altimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Be 2 and Mental DOMINICK RUGGIERO ANNA COSENTINO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) important: If Item 27 is any injury or other tra once. CAMILLA CARNAGGIO(SISTER) 3025 MARDEL AVENUE - BALTIMORE, MD 21230 20b. Placa of Disposition (Neme of cometery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State LOUDON PARK CEMETERY 5/14/97 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE 22. Name end Address of Fecility 21. Signature of Funeral Service Licenses HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21230 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset end Death **Physician** intraparenchymal Immediate Ceuse (Final disease or condition resulting in death) Examiner Physiclan/Medical Examiner the deeth certificate be executed Sequentially list conditions, if sny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last pue Due to (or as a consequenca of) Box 68760. the Due to (or as a consequence of): P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown The law requires that signed b Records, þ 24b. Were sutopsy tindings available prior to Completed 24e. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Dinpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death To the Hospital or Attending Pt within 24 hours efter death.

To the Funeral Director: After th completely filled in by the funeral Date of Injury (Month, Dey Year) 28c. Injury st Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner ss stetled.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) end manner stated. Medicai 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier mb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 s. Hanover St Baltimore, mb 21225 James

DHMH 16 Rsv 6/95

Registrar



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TO B	19a. INFORMANT'S NA Cynthia		dley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City 3320 Dudley Avenue Balt												
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	ty Burial 2 □ Cre 4 □ Donation 8 □	omation 3 R	lamoval from Stata	cemetery, cr	rematory or o	ther place)			A C	- 1				ngs Mi			
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TED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list of farry, leading to cause. Enter UND CAUSE (Disease of that initiated evan resulting in death PART II. Other alg DID TOBACC 25. WAS CASE REFER EXAMINER? 1 YES 2 MANNIFR OF DEAT 1 Natural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 29b. SIGNATURE AND	conditione, immediate ERLYING prinjury its indifferent conditions of the conditions	DUE T d	O (OR AS A CONSIDE OF OR AS A CONSIDER OF DELEGATION OF INJURY Day, Year) OF INJURY — At It of Injury Day, Year) of my knowledge, of exemination and/or exemination	EQUENCE OF DEATH ACE OF DEATH No. 1 Page 16 Pa	F): In the Un O A TH (Check OTHES 4 Nun AB OF JURY M street, fact	NO [only one and one and one and one and one and one and one and one and one and one and one and one and one and one and one and and and and and and and and and and	I UNIO	given in CERTAli Residence NO	Part I. 6 Other 26d. DE 261. LOCCITY to the case time, deta	24s. WAS A PERFC 1 YES or (Specify) SCRIBE HOW CATION (Street or Youn, State	IN AUTOPSY DRMED? 2 YNO If INJURY OX It and Number The anner as still and the to to the still and the still and the still anner as still a	CCURED or or Rural ated.	D. WERE AUTOPS: AMAILABLE PRICOMPLETION CO OF DEATH? 1 YES 2 [

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

See of the see that I want

A selfer of the

State of Maryland / Department of Health and Mental Hygiene

14726 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of the th 2. Dete of Death **Physician** May 9, 1997 Veal JONAS SARAKAUSKAS 12.2040 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 9628 Rocksparkle Row Columbia Howard County 8. Dete of Birth (Month, Day, Year) May 25, 1925 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1₽M 2□ F Deys Hours 71 Yrs. Lithuania Director Usuel Residence of Decedent 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yas 2 ☐ No Director Maryland Howard County Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Counfry? b 9628 Rocksparkle Row 21045 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yas, Give Yeer or Detes: 1 □ Never Married 2 □ Married by 1 ☐ Yes 2 ☑ No Specify: Specify: white **3**DWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) master craftsman ULA Ltd. 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If item 27 is marked other any Injury or other traumatic event. 18. Mother's Neme (First, Middle, Maiden Surname) Be Petras Sarakauskas Ieva Kilmonyte 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Al Grintalis/son-in-law 9628 Rocksparkle Row, Columbia, Maryland 21045 20e. Mathod of Disposition 20b. Plece of Disposition (Nama of cemetery, cramatory or other place) 20c. Location - City or Town, Stele 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removal from State 4 □ Dention 5 □ Other (Specify) Baltimore-Washington Cramatory 12MAY97 Laurel, Maryland 21. Synature of Funeral Service Licensee 22. Name end Address of Facility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 and Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximete Intarval Batween Onsef end Deeth **Physician** /Medical dieta Causa (Finel metastatic prostate ulting In deeth) Examiner Due to (or es a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Causa (Diseese or Injury thet Initieted avants resulting in daeth) Lest Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medicai Due to (or es a consequence of). P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceusa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown None Division of Vital Records. pe d à 24b. Wera autopsy findings aveileble prior fo completion of ceuse of death? Completed 24a. Wes en eutopsy performed? page 2 s 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, Be 25. Wes cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Oufpatient 3 | DOA Othar: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Death Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 5 Pending Investigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarminad 3 Sulcide 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify) in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Cartifier 🖼 Certifying Physician: To tha best of my knowladga, daath occurrad at the time, dete end place, and dua to tha causa(s) and menner as stated. Medical 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the ceusa(s) end manner sfeted. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16in D41139 May 9, 1997 30. Name and eddrass of person who complated ceusa of daath (Item 23e) (Type, Print) Clement Knight, MD, 11065 Little Patuxent Parkway, Columbia, MD 21044 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Suka Tavidson-Randelle Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

16727 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Physician Month Smouse Wellington Junior 4:00 AM May 13 1997 /Medicai 4a. Fecility Neme (If not institution, give street end number) 4c. County of Deeth
Baltimore 4b City Town or Location of Deeth Examiner Saint Joseph's Hospital Center Towson If Under 1 Year | If Under 24 Hrs.

Months | Deys | Hours | Min. 5. Social Security Number Birthpleca (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys 232-22-6545 1**X** M 2□ F 78 Yrs. Director Jan. 26, 1919 Maryland Usuel Residence of Deceden 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Maryland Baltimore Rosedale Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? b must be 8106 Timber Brooke Road 21237 U.S.A. larms 23a 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Aero Space Painter d 2 should be filled the and Mental Hygis 7 is marked other 1 Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked of any Injury or other trainmatic Albert Smouse Bertha Shatzer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Sheri Riedlbauer (DAUGHTER) 9804 Magledt Road Baltimore, Md. 21234 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removel from Stete Oakland Cemetery 5/15/1997 Oakland , Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensia 2. Name end Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue 21221 23a. Part 1. Enter the disease, or complications that cay led the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Examiner that the death certificete be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Lest end physiclan er s the bunai-t Box 68760. Physician/Medical attending for use as use signed by the a P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. Completed by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to peed completion of cause has le 2 page 1 Yes 30KNn 1 ☐ Yes 2 ☐ No certificate Vital al or Attending Physician: The seftar deeth.

Il Director: After this certificated in by the funeral director, ps Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) P 1 Yes 2 No 2 ER/Outpetient 3 DOA Division of 27. Manner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1X Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours eft To the Funeral Di completely filled in **EXECUTIFYING Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the best of examination and or lovestigetion, in my opinion, deeth occurred et the time, date end piaca, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the Vithin 2 29b. Signature end title of @ 29d. Dete signed (Month, Dey, Year) May 13, 1997 30. Name end eddress of completed cause of deeth (Item 23e) (Type, Print) 7600 Osler Drive Towson, Md. 31. Date filed (Month, Day, Year) State Registrar

(HW)

was to the second secon

State of Maryland / Department of Health and Mental Hygiene

4728

Birthplace (State or Foreign Country)
 Maryland

10d. Inside City Limits 1 ☐ Yes 🏖 No

21221

3. Time of Death

1:21 am

										Cel	lincal	e oi	Deall	/		Reg.	No.			
		Physic	an	Decedent's Nam	e (First, Midd	le, Las	1)								2. Date of D	eath	Dey	Year	3. Time	
		Physici /Medi		Elsie					STEI	NKE					May	1	11, 19	97	1:2	
		Exami		4a. Facility Name (/											ocation of Dee	th	4c. County	of Deat	h	
				Franklin	-			I Cer	nter				Rose				Balti	more	2	
		Funeral Director		5. Social Security Number 214-50-2902 6. Sex 1 Months 7. Age (In yrs. lest birthdey) 88 Yrs. H Under 1 Year Months Deys									If Unde Hours	Min.	8. Dete of B (Month, D July 2	Co	Birthpiace (Stet Country) aryland			
		2 .		Usual Residenca of																
		with the Maryland a or 28a-f show be notified at	tor	Maryland	Balti		æ	1	10c. City, Town or Location ESSEX										10d. Inside	
		th with the 23a or 28 unt be not	Funeral Director	10e. Street and Nur 1508 Brek		ne					10f. Zip	Code 1221			10g. Citizen of Whe					
(180 N	H	by	11. Maritel Stetus 1 ☐ Never Marri 3 ☐ Widowed			12. Was Dec Armed F 1 Yes If Yes, G Year or I	orces? 2 X No ive	er in U,S.		Was Deced f Yes, space				pecify Yes or N o Rican, etc.)	0-		ck, White	rican Indien, e, etc.	
\		1	Completed	(Spec	15. Deceder	nt's Ed	de completed,) (1-4or 5+)	16a	16a. Decadent's Usual (Give kind of work life. DO NOT use			pation during mo	st of wor	king	16	16b. Kind of Business		Industry	
	2	The state	E O	6	modify (0-12)		College	(1-401 5+)		Housewife							Own	Hon	Home	
	g	tal Hyg d othe event,	Be	17. Fether's Name		Last)									ne (First, Middle		iden Sumen	ne)		
	ya	thould by d Menta marked marked	10 8	Fred W. Brehm Amanda Hughes																
	Mar	nd 2 auth ar 27 is r frau		19a. Informant's Neme/Reletionship (Type, Print) Carol M. Besnoska (Daughter) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, St. 1914 Poplar Rd. Essex, Md. 21221												Stete, 2	(ip Code)			
	Baltimore, Marylan	t at he	ulary.	20a. Method of Disp 1 ■ Burial 2 4 ■ Donation	Cremetion			State	20b. Placa o cemete	ry, cren	netory or o	ther ple	ce)	5/1	Date 4/1997		c. Location -		Town, State	
	Balt	permit. Pa Departmen Important: any injury snse.		21. Signature of Fu	Mirái Sephe	Liven	da J	1	(.	B		zins	ki F	mera	al Home			ьм	2122	
		Physician		234. Part1. Enter If shock, or hear	ne disease, or rt failure. List	comp	callour that ne cause on	caused the	e death. Do	not ent	er the mod	le of dyl	ng, such e	s cardied	Avenue or respiretory	errest	sex,	WCI.	Approximinterval E Onset an	
•		/Medical Examiner		Immediate Cause (disease or conditio resulting in deeth)	Final n		a. Sep	sis											3 da	
		p ii	liner			_	h	Du	ie to (or as a	conseq	uenca of):									
	20,	icata be asscuted physician and s the bunel-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury the britished area for the cause of the											1					
	P.O. Box 68/60,	et the death certificata be axecuted the strending physician and ateched for usa as the bunet-transit	Physician/Medical	that initiated events resulting in death) t			d	Du	e to (or as a	conseq	uence of):							1		
	. r	he at	sici	Pert li. Other signifi	cant condition	ons co	ntributing to d	leath but r	not resulting i	n the ur	nderiying c	ause gi	ven in Par	t i.	23b. Dic	tobe	cco usa co	ntributa	to the caus	
- 2	Ţ.	d by the	Phy	Congesti	ve He	art	Failu	re							1	Yss	2₩ No	3 🗆 Pı	robably 4	

Approximate interval Between Onset and Death 3 days contribute to the cause of deeth? 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were eutopsy findings evallable prior to completion of cause of death? 24e. Wes en eutopsy performed? Coronary Artery Disease Chronic Renal Insufficiency 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner?
1 ☐ Yes ② No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) M☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Date of injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. injury at Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medicat Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier

To the Hospital or Attending Physician: The law requires thei within 24 hours after death.

Within 24 hours after death.

The Funeral Director: After this certificate has been signed b completely filled in by the funeral director, page 2 should be date Division of Vital Records.

by

Completed

Be

2

Medical Certification:

29b. Signeture end title of certifier

111 Pay Internal Med

29c. License number RD1912

29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Selv Auro 9000 Franklin Square Drive Baltimore, Maryland 21237 SEIN AUNG

31. Date filed (Month, Dey, Year) State Registrar

32. Registrar's Signature ulia Davidson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14729 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 13 **Physician** Month Horold 30 AM may /Medical 4a. Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BATT no ne
If Under 24 Hrs. 8. Data of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number Nursing Center

7. Age (In yrs. last birthday) If Undar 1 Yaar KNO115 9. Birthplace (State or Foreign Country) 6. Sax **Funeral** 10M 20F Days Yrs. 4/1-36-2961 Usual Residence of Decedent Director TENNESSE 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tras 2 No Director MID BALTIMUNE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA LOL 29 22 Sout Ane 2 Funeral Was Dacedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 25 No If Yes, Giva Yaar or Datas: 1□Yes 202110 þ White 3 □ Widowed 4 □ Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry d 2 should be filled within 7; th and Mertal Hygiene. 7 is marked other than "na College (1-4or 5+) Elementary/Secondary (0-12) AKer NA 18. Mother's Name (First, Middle, Malden Sumama) 17. Father's Name (First, Middle, Last) Be UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 28 FL, Ball, wore, Mb. 21701
Date 20c. Location - City or Town, Stete 861 Park Ave Separtment of Health mportant: If Item 27 i Debra HamillON Grandian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 □ Burial 2 □ Cremation 3 □ Removal from State ò 22. Name and Address of Facility Albert P. WyLie 7/H PA 4 ☐ Donetion 5 ☐ Other (Specify) 6100 21. Signature of Funaral Service Licental 23a. Pert1. Enfer the disease, or completely is that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final COLON CANCER rionths disaasa or condition resulting In death) Examiner Due to (or as a consequence of) Examiner SCHIZOPHRENIA physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequance of): ANEMIA Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 108 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one)

P.O. Box 68760. Records, Division of Vital To the Hospital or Attending Physician: After death. efter death.

Saltimore, Maryland 21215-0

Be Certification: To 27. Manner of Death 29a. Certifier

within 24 hours efter der To the Funeral Directo completely filled in by th Medical

State Registrar

Saba Siddugi PHYSICIAN 29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steted.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Typa, Print) 405

STEMMERS RUN

Registrar's Signature

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Tima of

28a. Date of Injury (Month, Day Year)

ROAD , BALTIMORE

Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)

28d. Describe how injury occurred

2/22/

31. Dete filed (Month, Day, Year) MAY 1 4 1997

29b. Signature and title of certifier

1 Yes 2 No

5 Pending

Investigation

6 Could not be determined

1 Natural

2 Accident

4 Homicide

(Check only one)

3 Sulcide



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Certification:	3 □ Su 4 □ Ho	icida	6 Could datem		28a. Place buildir	of Injury - At ng, atc. (Spa	homa, farm	, straat, fac	tory, office		28f. Location City or	on (Street ar Town, State	nd Numbe	r or Rural	Routa Number,	
U	29a. Cartifi	ar 1 conly 2	Certifyir Medicai	ng Physic Examine	lan: To tha r: On tha ba and mann	sis of axami	nowledga, d	aath occurr or invastigat	ed et tha tir ion, in my c	ma, data and pl ppinlon, daath o	aca, end due to ccurred at the ti	tha ceuse(s) me, dete and) and man	nar as sta nd dua to	ated. tha causa(s)	
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edicai	29b. Signa 30. Nama a	nd addres	Mays	Cal	pleted cause		em 23e) (Ty			ARITAI	•	M/ OSPIT		9,	1997	



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State of Maryland / Department of Health and Mental Hygiene

Items; 18,19a perFH G-747 5/30/97 reb Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Daath 3. Time of Death **Physician** Francis W. Smith Jr. May 1997 /Medical 11 9:30 P.M. 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Deeth **Examiner** 2 - Gene Avenue Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Deys Hours Min. (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Birthplaca (Stata or Foraign Country) Months 1 M 2□ F 213 18 9619 Yrs. Director March 21,1920 Maryland Usual Rasidanca of Decedant 10a State 10b. County 10c. City, Town or Location 28a-f show 10d, Insida City Limits ust be notified at Director Maryland Anne Arundel 1 ☐ Yes 2 No Pasadena 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? b 238 2 - Gene Avenue 21122 U.S. Funeral 11. Marital Stetus 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Ricen, etc.) 14. Raca - Amarican Indien, Black, White, etc. 17∑ Yas 2 □ No If Yas, Give Yeer or Datas: ₩.₩. II 1 Nevar Married 2 Marriad 1 ☐ Yas 2 🕱 No Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedant's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacadant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me Eiamentary/Secondary (0-12) Collage (1-4or 5+) filed with Machinist 12th U.S. Coast Guard Baltimore, Maryland 17. Father's Nama (First, Middle, Last) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If them 27 is marked oth any injury or other traumatic even 18. Mothar's Nama (First, Middle, Maidan Sumame) Be LORETTALorretta Styles Francis W. Smith Sr. 10 19a. fnformant's Name/Raiationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Gertrude * Smith wife 1204 Valley Road Pasadena, Maryland 21122 20b. Placa of Disposition (Nama of cemetary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Crametion 3 □ Ramoval from Stata 5/15/97 Crownsville, Maryland Md. State Veteran Cem. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 raminousky 23af Part 1. Enter the disease, or confplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. The only one cause on each line. Physician /Medical Immediate Cause (Final Respiratory disease or condition rasulting in death) hours Examiner Dua to (or as a consequence of): Examiner Esophageal year caucer The law requires that the death certificate be axecuted burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Diseasa or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria **Physician/Medical** Due to (or as a consequence of) id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24e. Wes en eutopsy performed? 24b. Wara autopsy findings aveilebla prior to complation of cause of death? peen ate has certificate 1 Yas 2 No 1 Yas 2 No the Hospital or Attending Physician: director 25. Was case rafarred to medical Be 28. Place of Death (Check only one) Hospital: Other: 4☐ Nursing Homa 5☐ Rasidenca 6☐ Other (Specify) 2 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. injury at Work? 28d. Dascribe how injury occurred Affer 1 Naturai 5 Panding invastigation death. 1 ☐ Yas 2 ☐ No Director: / 2 Accident 3 Suicida 6 Could not be datamined 28a. Piaca of injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stata) 4 Homicida To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and piace, and due to the cause(s) and mannar as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and mannar stated. 29a. Cartifian Medical one) 29b. Signetura and title of certifiar 29c. License number 29d. Deta signed (Month, Day, Year) Laurence Quotin Dayle, M. D. 123809 5/12/97 UM 30. Nema and address of parson who complated causa of death (itam 23a) (Type, Print) Austra Dayle, m.D. Greenelowin Cancer Ctr., 22 S. Greene St., Baltmore, MD 31. Data filed (Month, Day, Year) State Registrar

DHMH 16 Rav 6/95



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MALL APPR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Yeer EUGENIA SUTTON 4b. City. Town, or Location of Deeth 1997 5:45A.M. 4a. Fecility Name (If not Institution, give street and number) 4c. County of Deeth BALTIMORE GENESIS-CATONSVILLE COMMONS BALTIMORE if Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Yeer Birthpiace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 1□M 21xF Days Hours 450-24-9763 Yrs 90 AUG 6, 1906 BONGNTON, AR Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 No Yes 2 No PULASKI LITTLE ROCK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6018 BRENTWOOD 72207 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Yeer or Dates: 11. Maritei Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ YesX X No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th GRADE SWITCHBOARD OPERATOR NEWSPAPER 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MAY PRICE EUGENE McDONALD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIAZ McKENZIE (NEPHEW) 45036 441 EAST MAIN - LEBANON, OHIO 20b. Placa of Disposition (Name of cemetery, crematory or other piece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State PINE CREST CEMETERY 5/14/97 ALEXANDER, AK 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signature of Funcial Service Licensee 22. Name and Address of Facility HUBBARD FUNERAL HOME INC 21229 4107 WILKENS AVENUE-BALTIMORE, MD 23a. Part 1. Error the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limit. Approximate Interval Between Onset and Death Immediate Cause (Final Jumonia 24 hx disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings avelleble prior to completion of cause of death? 24a. Was an autopsy Hypothyordiem 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

/Medical Examiner sicien end buriel-transit physicien the been signed by the a

Records, P.O. Box 68760

Division of Vital

Examiner

Physician/Medicai

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Department of himportant: If ite

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Funeral

Director

27. Manner of Death

1 Naturel

2 Accident

4 - Homicide

3 ☐ Suicide

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending

investigation 6 Could not be determined 28a. Date of Injury (Month, Day Year)

28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. tnjury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signeture end title of certified

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Formy Rd, Balthuoue, MD-21227 31. Date filed (Month, Day, Year)

Kaja MD

State Registrar 32. Registrar's Signature



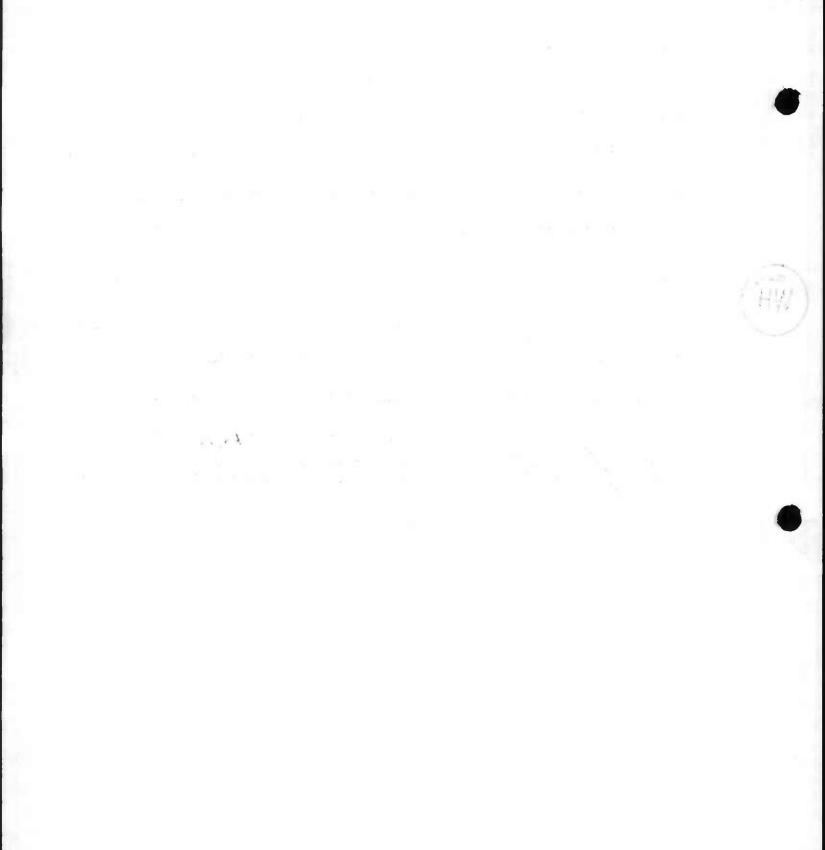
State of Maryland / Department of Health and Mental Hygiene
ITEM# 10c PER F.H. FLM#G747 5/16/97 J.A. Certificate of Death

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or zea-f show be notified at Director	ST. AGNES 5. Social Security Numb 212-09-208 Usuel Residence of Dec 10a. Stete 101	HOSPIT <i>A</i> 6. S	L	n <i>ber)</i>			4b. City, T	own, or Lo	cation of Deeth	4c. Count	v of Doeth	
tor 28a-f show be notified at ofrector	212-09-208 Usuel Residence of Dec 10a. Stete 10l MD	1 1	ax				BALT	IMORE			/A	
be notifie Directo	10a. Stete 10a		□ M 2□ % F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Months	ear If Under Hours	Min.	8. Dete of Birth (Month, Dey SEPT 28	, Year)		(State or Foreig MORE, MD
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marks smarks smarks	19e. Informant's Name/	Reletionship (7	ypa, Print)		19b. Mailir	ng Address (S	treet end Num	ber or Rura	al Route Numbe	r, City or Town	, Stete, Zip Coo	(e)
ar tre	JOHN L. SC	HNEIDE	R(SON)		126 P	EARL S	TREET -	FT.	COLLINS	, co.8	0521	
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al Director: After t led in by the funera Certification:	3 ☐ Sulcida 6 4 ☐ Homicida	Could not be datermined	286. Piece	of Injury - At hing, etc. (Specif	ome, farm, str fy)	eet, factory, o	ffice		28f. Location (S. City or Town	traet end Num n, State)	ber or Rural Ro	ıta Number,
To the Function of the through completely filled in by the funeral Medical Certification:	29a. Certifier 12 (Check only one)	Certifying Phy Medical Exam	rsician: To the iner: On the ba end mann	sis of axamina	owledga, daath ation end/or Inv	occurred at treating estigetion, in	ha tima, data a my opinion, da	nd plece, ath occurr	and due to the c ed at tha tima, d	ause(s) and m lata end place,	enner es steted , end due to the	ceuse(s)
To th	29b. Signature and title	of certifier				29c. L	cense number		2	9d. Dete signe	ed (Month, Dey,	Year)
7	30. Nama and addrass of	us	M.D.				PO 9	886	ŝ	5-	6-9-	7

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Yaar)



State of Maryland / Department of Health and Mental Hygiene

1 734 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death Month **Physician** 19997 Elizabeth H. Sartin 8:00A.M. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Nursing Home Dundalk Baltimore Months Days Hours Min. Ap 101 Day 1 (9er) 1922 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 25 F Months 75 Yrs. 214-20-5719 Director W. Virginia Usual Rasidance of Decedant the Maryland 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 ☐ Yas 2 ☐ No Director Md. Baltimore Dundalk 288-7 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? ò 8144 Del Haven N Rd...
12. Was Decedant Evar in U,S. Armed Forcas?
1 □ Yas 2♥ No If Yas, Giva Yaar or Datas: U.S.A.

14. Race - American Indian,
Black, White, atc. Funeral 21222 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 Navar Married 2 Marriad Specify: White 1 ☐ Yas 2 No Specify: Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Spacify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 21215 Elamantary/Secondary (0-12) Collaga (1-4or 5+) 6yrs. Housewife Home altimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be Pages 1 and 2 should be nent of Health and Mental Earl Austin Cosner Katheryn Harper 2 19a, Informant's Name/Relationship (Type Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) × Department of Health a Important: If Hem 27 is any injury or other trax Lois Burkhardt/daughter 8144 Del Haven Rd. Dundalk Md. 21222 20b. Placa of Disposition (Nema of camatary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ACramation 3 ☐ Ramoval from State Metro Crematory Baltimore May 8 4 ☐ Donation 5 ☐ Othar (Specify) store of E 22. Nama and Addrass of Facility Connelly Funeral Home of Dundalk 23a. Part / Entar tha disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest,

Approximately a complication of the caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest,

Approximately a complication of the caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, 21222 intervel Between Onsat and Death **Physician** MYOCARDIAC INFARCTION

Due to (or es a consequenca of):

REJ PINATURY FAILVIE /Medical Immedieta Causa (Final disaasa or condition rasulting in deeth) Examiner Physician/Medical Examiner physician and s the buriel-transit that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disease or injury thet initiated avants rasulting in death) Last P.O. Box 68760. Dua to (or as a consequence of): signed by the el d be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ Hospital or Attending Physician: The law requires 24 hours effer death.

24 hours effer death.

25 Fueral Director: After this certificate hes been sign selly filled in by the tunerel director, page 2 should be selly filled in by the tunerel director, page 2 should be 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed 21000 1 Yas 2 No Division of Vital Be 25. Wes casa rafarred to medical examiner? 26. Piece of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Certification: To 28c. injury et Work? 27. Manney of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 1 Netural 5 Panding 1 ∏Yes 2 □ No invastigation 2 Accident 3 Sulcida 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide To the Hospital within 24 hours of To the Funeral Completely filled 1 Certifying Physicfen: To the best of my knowledge, death occurred et the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, deta and place, and due to the causa(s) and manner stated. 29a Cartifiar Medical (Check only one) 29c, Licansa number 3 2 3 5 3 0 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier 30. Name and address of person who completed causa of daath (Itam 23a) (Type, Print)

HUHDK K CHATTENTEE 3927, ANNAPOLIS NOTM 21227. 32 Registrar's Signature 31. Data filed (Month, Day, Yaar) State MAY 1 Registrar

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p21.

State of Maryland / Department of Health and Mental Hygiene 97

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				Cei	rtificat	e of	Death			Reg. No.			, 0 0
	1. Decedant's Nama (First, Midd	la, Last)							2. Data of De	eath	L I lites	3.	Tima ot Death
iysician Medical	TREGERICK	LURNE	K						May	Day 13	199	7 1	7:50An
caminer	4a. Facility Nama (If not institution						4b. City, To	own, or Lo	ocation of Daal		County of Dea		1.001
	Gilchrist						Tow	son			Balti	imore	9
neral	5. Social Sacurity Number	6. Sax	7. Aga (In yrs. last b	irthday)	If Undar		If Undar	24 Hrs.	8. Data of Bi	rth			(Stata or Foreign
ctor	215-38-9434	1€M 2□ F	(m zu , O)						(Month, Di 6-30-			ountry) aryla	
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A notified	10e. Street and Number				10f. Zip	Coda				10g. Citiz	an of What Co	ountry?	
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000		5+		Phys	sicia	n				D€	entist		
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2	Frederick J	. Turner					Fi	cance	es M.	Brown	1		
1	19a. Informant's Name/Raletions	hlp (Type, Print)	19	b. Meilin	g Addrass	(Stree	t and Numb	er or Run	al Route Numb	er, City or	Town, Stete,	Zip Code	9)
	Mr. Frederick A	. Turner,	Jr. (Son)	13	306	Jef	fers (Court	, Tows	on, M	Marvlan	nd 21	204
5	20a. Method of Disposition		20b. Place	of Dispos		na of		T	Date		ation - City or		
6	1 ☑ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (S		Stata Loudo						5-15-97	Balt	imore,	Mar	vland
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an al	Immediata Causa (Final	,	0				. 1		,	1		Orise	ot and Death
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ert	4 Homicide	buildi	ng, atc. (Specify)		,,				City or To	wn, Stete)			
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edical	(Check only 2 Medical I	Examinar: On the be	best of my knowledg asis of axamination ar nar statad.	nd/or inv	astigation,	In my	opinion, daa	th occurr	ed at the time,	deta and p	place, and due	a to tha c	eusa(s)
N N	29b. Signature and title of Ortifler	1 ,1	11 1		29c.	Licens	sa numbar			29d. Data	signed (Mont	th. Day V	Year)
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State of Maryland / Department of Health and Mental Hygiene 14736 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Month SUSAN WILLIAMS. MAY 11,1997 4:20p /Medical 4e. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 11-17-56 Birthplace (State or Foreign Country)
 Md • 7. Age (In yrs. last birthday) **Funeral** 1□M 2□√F 40 Vre 217-68-2403 Director Usual Residence of Decedent the Meryland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Md Na Baltimore 10e Street and Number 10f. Zin Code 10g. Citizan of What Country? 424 Lakewood Avenue 21224 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. filed within 72 hours after of Hygiene. ther than "natural", or lter 11 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) 2yrs. 12th Grade Crossing Guard Baltimore City permit. Pages 1 and 2 should be file Department of Health and Mentel Hy, Important: If them 27 is marked othe any Injury or other treumatic event 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be Robert Η. Williams Pauline 2 Sampson 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Donald B. Young 424 Lakewood Avenue Baltimore, Md. 21224 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Mem. Pk.Cem. 05-16-97 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Baltimore, Maryland 21202 23a. Part1. Enter the disease, or complications that daused the death. Do not entar the mode of dying, such es cardiac or respiratory arrest, shock, or heart failura. List only ona causa on each line. WM.C. March FH 1101 E. North AVenue **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 1 WTTHERWINE 2 DAYS HELLWORNIAGE Examiner Due to (or as a consequence of) Physician/Medical Examiner The lew requires that the death certificete be executed physician end the bunal-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseasa or Injury that initiated evants resulting in deeth) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence ot) 80 attending p ed by the s Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Nonknown ρ been si 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s 2 No certificate 1 Tyes or Attending Physician: director, Be 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Pinpatient Certification: To 2 ER/Outpatient 3 DOA this funerel 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Affer s after dea... 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, straet, tectory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 - Homicida To the Hospital or A within 24 hours after To the Funeral Director Completely filled in b 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MD \$ 30. Nama and address of parson who complated causa ot death (Item 23a) (Type, Print) - Verology, Path 509, ~ HH, Baltwere, MD Dep alex a Pards ma -State Registrar

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Piease Type or Print in Biack indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of	of Death		Reg. No.	, ,	14707					
Physiciar	Decedant'e Nama (First, Middla, Last)				2. Data of De	eth Day_	Year	3. Tima of Death					
/Medica	Audrey Mae Wer	ner		4h Oih Taua as l	MAY	12,	1997	9:45p1					
Examine	4e. Facility Nama (If not institution, give street Belair Nursing Home and R	3.14 (3.11)	ton	4b. City, Town, or Belair	Location of Dynam	4c. County		0					
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last bi	irthday) If Under 1 Ye	ear If Under 24 Hrs.	8. Data of Birt			e (State or Foreign					
Director	213-05-3801	2 X) F 83	Yrs. Months De	ys Hours Min.	March .	10,1914	Maryla	e (State or Foreign					
D .	Usual Rasidance of Decedent 10a. Stata 10b. County	10c. City, Tow	um ar Location										
ith the Maryland or 28a-f show se notified at							100	I. Inside City Limits 1 ☐ Yes 2 🛣 No					
or 28a-f s	Maryland Harford	1	Edgewood 10f. Zip Cod	9		10g. Citizan of V	What Country						
T Pe o			21040			United S							
		Was Decedent Ever In U.S.					e - American						
	1 Nevar Married 2 Merried	Armed Forcas? 1 ☐ Yes 2 📉 No		of Hispenic Origin? (S Juban, Mexican, Puert	o Rican, atc.)		ck, Whita, atc.						
WIN	Ø Widowed 4 □ Divorced	If Yas, Giva Yaar or Datas:	1 □ Yas 2 X N	No Specify:		Specify	· Whit	е					
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工芸製	20a. Mathod of Disposition		of Disposition (Nama of ary, cremetory or other p		Data	20c. Location -). Stata					
unt: If It	1 ☐ Burial 2 🛣 Cramation 3 ☐ Ramo 4 ☐ Donation 5 ☐ Othar (Specify)	oval from Stete			E/14/07								
ortan injur	21. Signature of Funeral Service Licensee	Timothy Harman	Service Com		5/14/97	Towson, M	ar y ranu						
Ded grad	Tumber S 4	Lillouly narrian	Leonard J	l. Ruck, In									
- c	23a. Part1. Enter the dise of the dise of the death. Do not anter the mode of dying, such as cardlac or raspiratory arrest, shock, or haent tailure. List only on cause on each line. Approximate interval Between												
Physician	shock, or haert tailura. List only on To	Onset ar											
/Medical	Immediata Causa (Final diseasa or condition		Preur	nem'a				2 day					
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end Fran	Sequentially list conditions,	Dua to (or as e	consequanca of):										
ettending physician and if for use as the burlal-transit	Sequentially list conditions, if eny, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury c.												
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certificate be executed ding physician end use es the burial-transit	d												
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After th funeral			Tima of 28c. In Injury	njury at Vork?	28d. Dascribe t	now injury occur	ed						
death. Stor: After y the funer	2 Accident invastigation 3 Suicida 6 Could not be			☐ Yas 2 ☐ No									
the character of the ch	4 Homicida datamined	 Placa of Injury - At homa, fa building, atc. (Specify) 	arm, street, factory, offic	ce	28f. Location (S City or Tox	Street and Numb vn, Stata)	er or Rural R	louta Number,					
urs a cur													
within 24 hours at your properties of the Funeral D completely filled in Medical Ce	29e. Cartifiar 1 Certifying Physicia (Check only one) 2 Medical Examiner:	n: To the bast of my knowledge On the basis of examination an	a, daath occurred et the nd/or invastigation, in m	a tima, data and place ly opinion, daath occu	, and dua to tha rred at tha tima,	causa(s) and ma data and placa,	nnar as stete and dua to th	ed. a cause(s)					
within 24 hours after to the Funeral Direct completely filled in by Medical Certifi	29b. Signeture end titla of certifler	end mannar steted.	29c. Lice	ense number		29d. Dete signe	d (Month Da	v, Year)					
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5		ated course of death from one i						<u> </u>					
	30. Nama and addrass of person who complete Kommetin NMR			nst Han	re De C	France A	10.21	078					
State	31. Data filed (Month. Day. Year)	32 Registrar's Signatura											
Registrar	MAY 1 4 1997 9	whie Bevidson Hand	300										
United the Day office	1 4 1001					- <u>-</u>							

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HOWARD L.WINTER, SR.

State of Maryland / Department of Health and Mental Hygiene 97 11738

					Ce	rtificate	of	Death			Reg. No.		19/50	
		1. Decedant's Nama (First, Middl	a, Last)							2. Data of De	eath	W75.	3. Tima of Death	
Physic /Med		HOWARD LINV	WOOD WINT	'ER						MAY			7:21 AM	
Exami		4e. Facility Nama (If not institution						4b. City, Tov	wn, or Lo	ocation of Deel				
		6101 LOCH RA	VEN BLV	/D.				BALT	IMOI	RE	N	1/2		
Funeral	Г	5. Social Security Number	6. Sax	7. Aga (In yrs	. last birthday	If Undar 1 Y	/aar	If Under 2	24 Hrs.		rth	9. Birth	oleca (Stata or Foreig	
Director		341-05-0486 Usual Rasidanca of Dacedant	1 ⊠ M 2□ F	84	Yrs.	Months D	eys	Hours	Min.	12/31,	12 (12)	Cour	ntry)	
of the page		10a. Stata 10b. County		10c. C	ity, Town or L	ocation						1	Od. Inside City Limits	
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ath with the Maryland 128 or 288-f show xest be notified at	Directo	10e. Street and Number				10f. Zip Co					10g. Citizen of	What Cour	ntry?	
D well		6101 LOCH RAV	EN BLVD.			21	23	9			110	: n		
9	Funeral	11. Meritel Status		cedant Evar in L	J,S. 13.	Was Decedan	t of H	Ispanic Orio	gin? (Sp	ecify Yes or Ne	r No- 14. Raca - American Indian,			
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6	P	3 ☑ Widowed 4 ☐ Divorced	Yaar or		II	ILI Yas 210	NO	Specify:			Specif		HTTE	
KIN A	Completed	15. Decedan (Specify only higher	t's Education	<i>(</i>)	16a. Dece	dant's Usual C	ccup	ation	of work	ina	16b. Kind of B			
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V V	Co	12th GRADE			UN	DERWRIT	ER				ta of Death onth Day Year Year Y 10 1997 7:21 AM of Deeth 4c. Country of Deeth N/A The of Birth Agy, Year) Ac. Country of Deeth N/A The of Birth Day, Year) Ac. Country of Deeth N/A The of Birth Day, Year) Ac. Country of Deeth N/A The of Birth Day, Year) Ac. Country of Deeth N/A The of Birth Day, Year) Ac. Country of Deeth N/A The of Birth Day, Year) Ac. Country of Deeth N/A The of Deeth Ac. Country of Deeth N/A The			
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Maryland d 2 should be fill th and Mental H IT is marked oth traumatic even	2	HOWARD E. WIN	TER					MAR	Y	BARK				
to the second		19a. Informant's Neme/Ratations	hip (Type, Print)		19b. Meili	ing Address (S	treet	and Numbe	r or Run	al Routa Numb	per, City or Town	, Stata, Zip	Coda)	
		HOWARD R. WINT	ER	SON	422	CIRCLE	D	RIVE (CLAR	KSVILLI	E, TN 3	7043		
T les 1		20a. Method of Disposition	a CDamousland		Place of Disponentary, cra	osition (Name of matory or otha	of r plac	ca)		Data	20c. Location	- City or To	own, Stata	
		4 □ Donation 5 □ Other (S			RELAND	MEMORT	AT.	PARK		5/13/9	97 Hillendale, MD			
altin mit. Pa partmer portant: y Injury 08.		21. Signatura of Funaral Sauce Licensea 22. Nama and Address of Facility												
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	1	23. 1911 Enter the disease of show, or heart failure. List	complications that	caused tha daa	th. Do not an	TOWSON, tar tha moda o	M f dyin	D 212	286 cardiac	or respiretory a	arrast,		Approximata	
Physician		show, or haart taitura. List	only ona cause on	aach lina.								i	Intarval Between Onsat and Death	
/Medical		Immediata Causa (Final	04	1 ernell	e cula i	111	- al	1721 114	real	11 -	decen			
Examiner		diseese or condition resulting in death)	a		or as a conse		-	10000	jewi	007	0013000	-		
	Jer			Due to (or as a conse	quence or).						1		
Box 68760, eath certificate be executed attending physician and ffor use as the burial-transit	Examiner	Sequentially list conditions	b	Due to (or as a conse	nuence of):								
O, exek an er rial-tr	EX	Sequentially list conditions, if any, laading to Immadiata cause. Entar Undarlying		000.00	57 do d 001100	quonos on.								
x 68760, erificate be executed fing physician end e es the bunal-transi	edical	Ceusa (Disaase or Injury that initiated avants Textificing in death I act Dua to (or as a consequenca of):												
68 tifica ng ph	Ped	resulting in death) Last												
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thet the death the by the atternation detached for the	Physician	Part II, Other significant condition	ns contributing to	death but not ras	sulting In the s	inderlying caus	a div	an in Part f		23b. Did	tobacco usa co	ntributa to	o the cause of death'	
the de tached	hy	Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part f.												
S, P es thet igned b	by F													
cords requires seen sign should be												24b. W	are autopsy findings	
w requires	jet										4 (CO	mpletion of cause	
Record The faw require ste has been si page 2 should	Completed									_				
		DE Was once referred to medical									100	10	⇒Yes 2∐ No	
of Vital Ri	o Be	25. Was casa rafarrad to medical axaminer?	Hospital:				Oth	or:		(Check only				
0 £ £ 5	-	1 Yas 2 No 27. Menner of Daath	11		28b. Tima o			4 LI NUI					y)	
Division of Vital or Attending Physician: The death. Director: After this certificat din by the funeral director, pa	Certification:	1 €Naturel 5 ☐ Pendin		of Injury nth, Day Year)	fnjury	f 28c.		k?` Yes 2⊡N		LOG. DUGGINGO	now injury occur	100		
ISIC thend death ctor: /	Ica	3 Sulcida 6 Could r	not be	o of Injuny . At h	ome form et			165 2		28f Location	(Street and Num	har or Rum	el Bouta Number	
Oiv A effer A in by	in a	4 ☐ Homicida datarm	inad build	e of Injury - At h ding, atc. (Specit	fy)	raat, factory, of	IICE			City or To	wn, Stata)	Jei oi nuit	II Hould Number,	
pital ours eral filled		29a. Cartifier 1 ☐ Cartifying	a Physician: To th	a host of my kas	wladaa daatt	h courred at the	no the	an data and	l alana	and due to the			t a t a w	
Division To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: After completely filled in by the funeral	edical		Examiner: On tha t	basis of axamina	ition and/or in	vastigation, in	my o	pinlon, daat	h occurr	and due to the ad at tha ti <i>m</i> a,	data end plece,	annar as s and dua to	tha causa(s)	
ithin omple	M	29b. Signatura and titla of cartifier		///		29c. Li	cans	a nu <i>m</i> bar			29d Data signe	d (Month	Day Year)	
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1/2		· · · · · · · · · · · · · · · · · · ·	V	"			. C	.M.E.			MAY 10	, 199	/	
Do,		30. Nama and eddrass of person		isa of death (Iter	n 23e) (Type,	Print)								
IJ		David K	Forber	111	Penn	Stree	et	, Bal	Ltin	nore,	Maryla	nd_2	1201	
Sta		31. Dete filed (Month, Day, Year) MAY 1	1997 32.	Registrar's Sign	airbon	Alandotto								
Regist	ar	MMI T	2 1001	a	-	24.								



No. 18 A LONG TOPE S THAN

State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner	
Funeral	

Director Completed by Funeral Director Baltimore, Maryland 21215-00 filled within permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If them 27 is treatived other
any injury or other traumatic event Be

> **Physician** /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, this funeral After 24 hours efter death. Puneral Director: A To the Hospital or Atter within 24 hours efter dea To the Funeral Director completely filled in by th

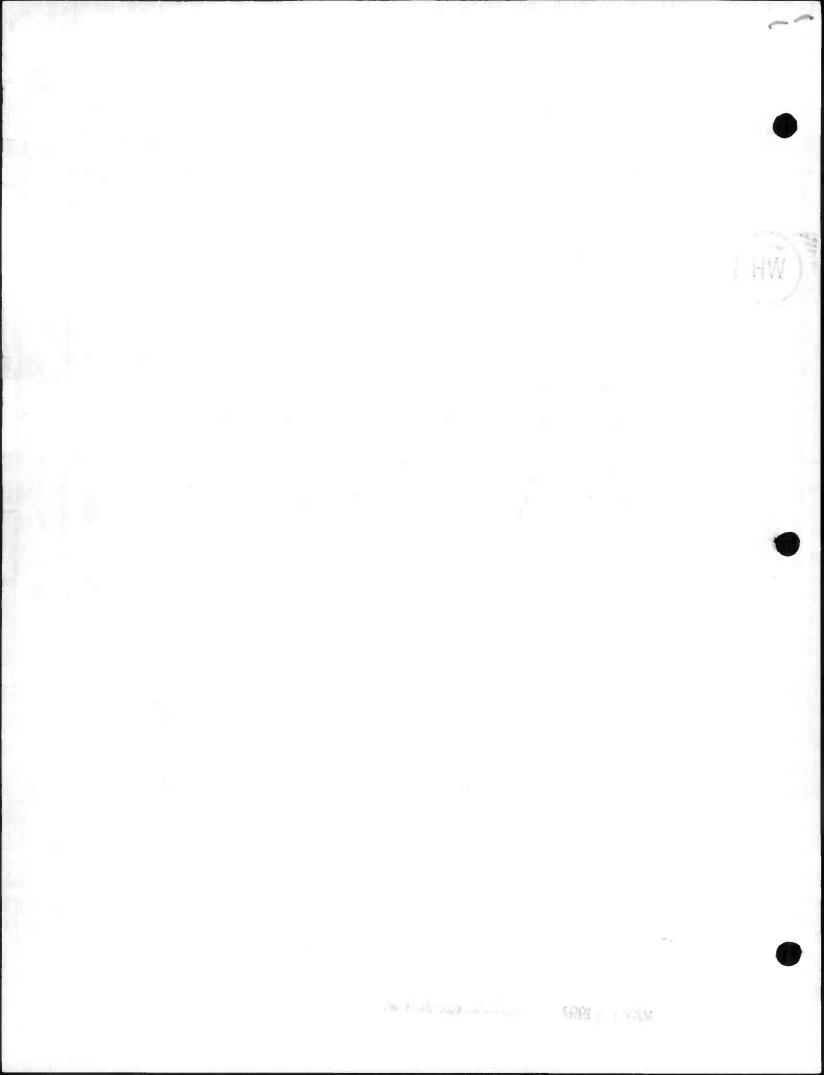
State

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month May12,1997 William Wilson Watkins 6:00am 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth 8217 Rosebank Ave. Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 1₩ 2□ F 215-12-6637 82 Yrs. March17,1915 Maryland Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Dundalk 1 ☐ Yes 2 No 10f. Zip Code 10e. Street end Number 10g. Citizen of Whet Country? 8217 Rosebank Ave. 21222 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify:White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 7 yrs. Assembler General Motors 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Harry W. Watkins Catherine W. Capps 19e. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Amelia Watkins wife 8217 Rosebank Ave. Dundalk Md. 21222 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 ☑ Burlal 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Wesley Chapel Meth. Cem. 5-15 Rock Hall Md. 22. Name end Address of Fecility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222

a, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, but only one cause on each line. Approximate Interval Between Onset and Death Immediete Ceuse (Finel diseese or condition resulting in deeth) Examiner watate Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medicai Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evelleble prior to completion of ceuse of death? Completed 24e. Wes en eutopsy performed? acrtic Stemosis seigne disorder 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1X Neturei 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

| Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner steted.

| Medical Examinar: On the best of exemination and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner steted. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Matibla H. So, no 5/13/1997 D26250 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) MATILDA H. SO, ROAD, LUTHERVILLE, MD. 21093. 1447 YORK 31. Date filed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Daath 3 Time of Death Day Thomas Anderson, Jr. Ε. April 23, 1997 3:50 P.M. 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery
9. Birthplaca (State or Foreign Takoma Park If Under 1 Yaar 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Devs 15€M 2□ F Months Min. Hours Yrs 524-12-2089 75 May 12, 1921 Colorado Usual Rasidance of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring 10a. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 507 Hillsboro Drive 20902 U.S.A. 12. Wes Decedant Ever In U.S. Armed Forcas? 11. Marital Stetus 13. Was Decedant of Hispenic Origin? (Spacify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Baca - Amarican Indian Black, White, etc. 1 XYas 2 No If Yas, Giva Yaar or Dates: WW II 1 ☐ Naver Merried 2 ☑ Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 5+ Clinical Psychologist Health Care 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumame) Thomas Edward Anderson Mary Georgina Pfistor 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Beryl L. Anderson 507 Hillsboro Drive Silver Spring, Maryland 20902 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burlai 2 ☐ Cramation 3 ☑ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Fort Logan National 05/01/97 Denver, Colorado 22. Name end Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Sil. Spr., Maryland 20901 s that caused tha daath. Do not antar tha moda of dying, such es cardiec or raspiretory errest, sa on aech lina. Approximata Interval Between Onset and Death Immediate Causa (Final disaasa or condition rasulting in death) 2 Weeken Mednoyi Due to (or as a consequence of): Month Tow Due to (or Sequantially list conditions, if any, laading to immadiate causa. Enter Undarlying Causa (Diseese or Injury that initiated avants rasulting in death) Last as a consequence of enrilen Jean Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evailabla prior to complation of cause of death? 24a. Wes an autopsy performed' 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa refarred to medical axaminar? 28. Placa of Death (Check only ona) Hospital:

Physician /Medical Examiner

Physician

/Medicai

Examiner

Director

Funerai

þ

Completed

Be P

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Evantuer mail be notified at

2 should be filed within 72 hours efter end Mental Hygiene. Is marked other than "natural", or ite

parmit. Peges 1 and 2 st Department of Health end Important: If Item 27 is n any injury or other traun

Baltimore, Maryland 21215-0020

Box 68760

the Maryland

with death

Examiner

ician and burial-transit physician s the burial 8 98 attending 980 ó ed by the a signed by t peed hes certificata this unerai After 2 2

Physician/Medical þ Completed Be L_o Certification:

edicai

1 Yes 2 No

5 Panding

investigation 6 Could not be datarminad

APR 29

27. Mannar of Daath

1 Natural 2 Accident

3 Suicida

(Check of one)

31. Date filed (Month, Day, Year)

29a. Certifian

4 Homicida

Division of Vital Records, P.O. or Attending Feftar death. 24 hours e Hospital pietaly To the I within 2 To the I complet 0+

State

Registrar

29b. Signature a Tur w ain

29c. Licensa number 3346

1 Tes 2 No

28c. Injury at Work?

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner steted.

29d. Dete signed (Month, Day, Year)

28f. Location (Straet and Number or Rural Route Number, City or Town, Stata)

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)

Yark way

28d. Dascribe how injury occurred

30. Name end addrass of person who completed causa of death (Itam 23a) (Type, Print)

28a. Data of Injury (Month, Day Year)

Hanover

- WASTAWA MP 227

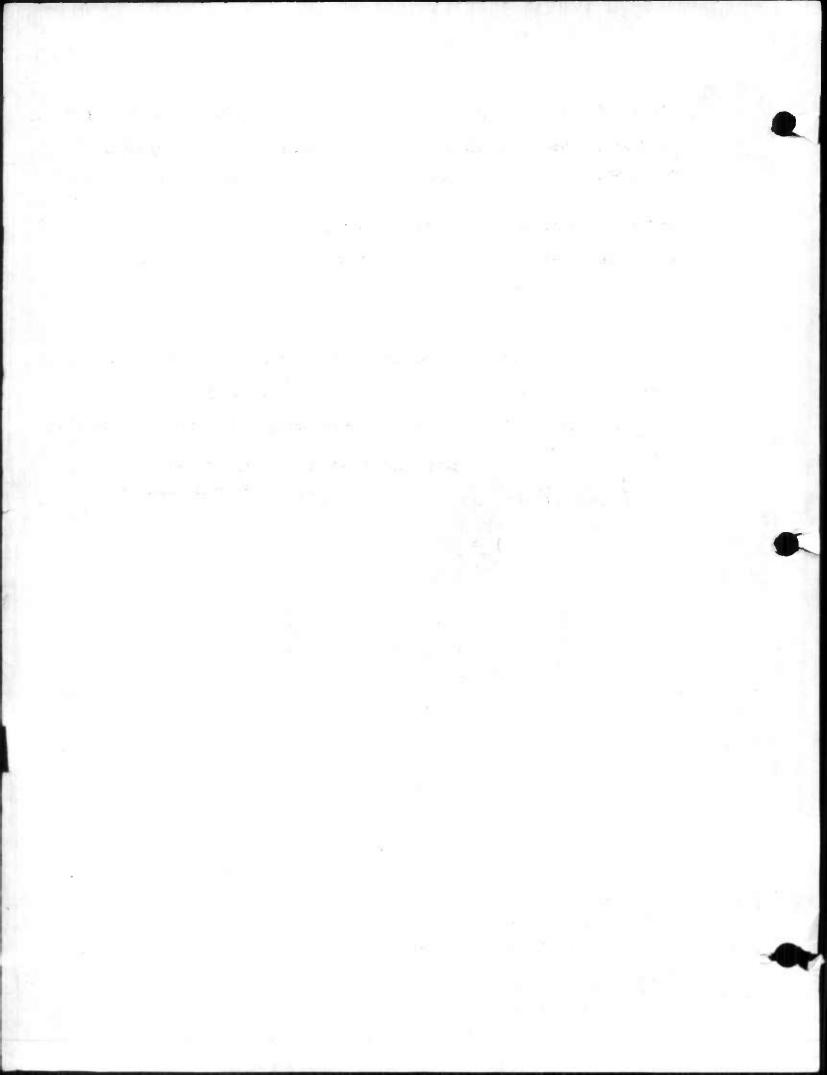
32. Registrar's Signatura chia Davidson

1 inpatient 2 ER/Outpatient 3 DOA

28a. Place of Injury - At homa, farm, straet, factory, offica building, etc. (Specify)

28b Time of

DHMH 16 Rev 6/95

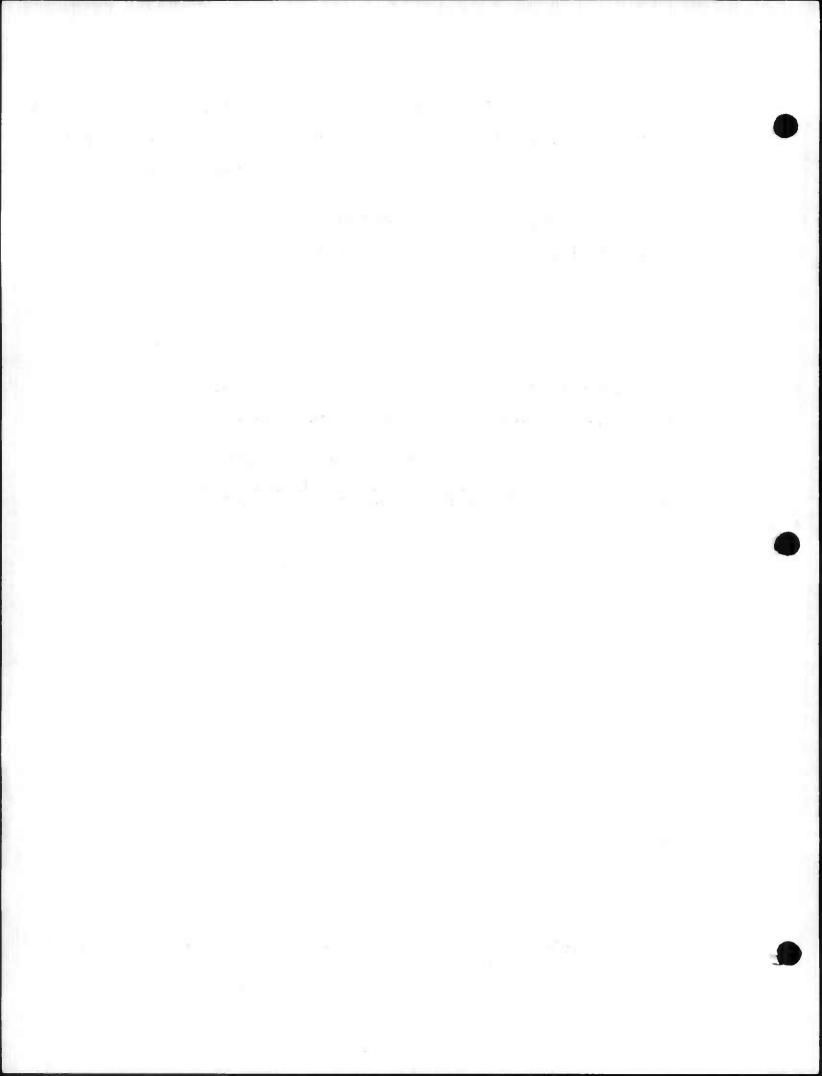


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth ^{Dey} 20, **Physician** Month Alade-Farri April 1997 2:22 a. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Daeth 4c. County of Deeth Examiner Silver Spring MONTGOMERY Holy Cross Hospital If Undar 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yeer) Apr. 20, 1997 9. Birthplece (Stete or Foreign Country)
Maryland 7. Aga (In yrs. lest birthday) **Funeral** 1**X** M 2□ F Hours Yrs. Director N/A the Maryland 10e Stete 10h County 10c. City, Town or Location 10d. Insida City Limits 28a-f show must be notified at Yes 2□No Funeral Director Gaithersburg Montgomery 10f. Zip Code 10e. Street end Number 10g. Citizen of What Country? ŏ 20877 17730 Topfield Drive 230 U.S.A. filed within 72 hours after death Items 2 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, atc.) 14. Race - American Indian, Bleck, White, etc. The Medical Examiner Never Merried 2 Married 21215-0020 ò 1 Yes 2 No Specify: by Specify: Black 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grede completed) Pages 1 and 2 should be filed within nant of Health and Mantal Hygiane. Int: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A traumatic event. Baltimore, Maryland 17. Fether's Nema (First, Middle, Lest) 18. Mother's Nema (First, Middla, Maidan Sumama) Idia T. Alade Shamsideen A. Farri 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code 0877 19a. Informent's Name/Relationship (Type, Print) nt of Health a : If Item 27 Is or other trai 17730 Topfield Drive, Gaithersburg, MD Shamsideen A. Farri 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. Silver Spring, MD 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cem. 4/28 21. Slopeture of Funeral Service License 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD Entar the unsaasa, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, or hear failure. List only one cause on each line. Approximete Intarval Betwe Onset end Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition rasulting in death) **Examiner** Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): Records, P.O. Box 68760 attanding physician Physiclan/Medical Due to (or es e consequence of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 20 No 3 Probably 4 Unknown by 24b. Were eutopsy findings aveileble prior to completion of causa of death? Completed 24e. Was an autopsy performed? peen this certificate has 280 No Division of Vital I or Attending Physician: after death.
Director: After this certifica Be 25. Wes cese referred to medical 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 1 ☐ Yas 2 No 1 Inpetient 2 ER/Outpetient 3 DOA Certification: 27. Menner of Deeth 28e. Date of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Panding Investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Sulcida 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide within 24 hours a To the Funeral D complataly filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piace, end due to the ceuse(s) end manner steted. 29a. Certifier Medical 29b. Signeture end title of certifier 29c. Licensa number 29d. Dete signed (Month, Dey, Yeer) on who completed cause of deeth (Item 23a) (Type, Print) Holy Cross Hospitar Silver Spring, MD GREGORY J. DOWNING 32. Registrer signeture 7 Duna Davidson-Randelle 31. Date filed (Month, Day, Year) State APR 2

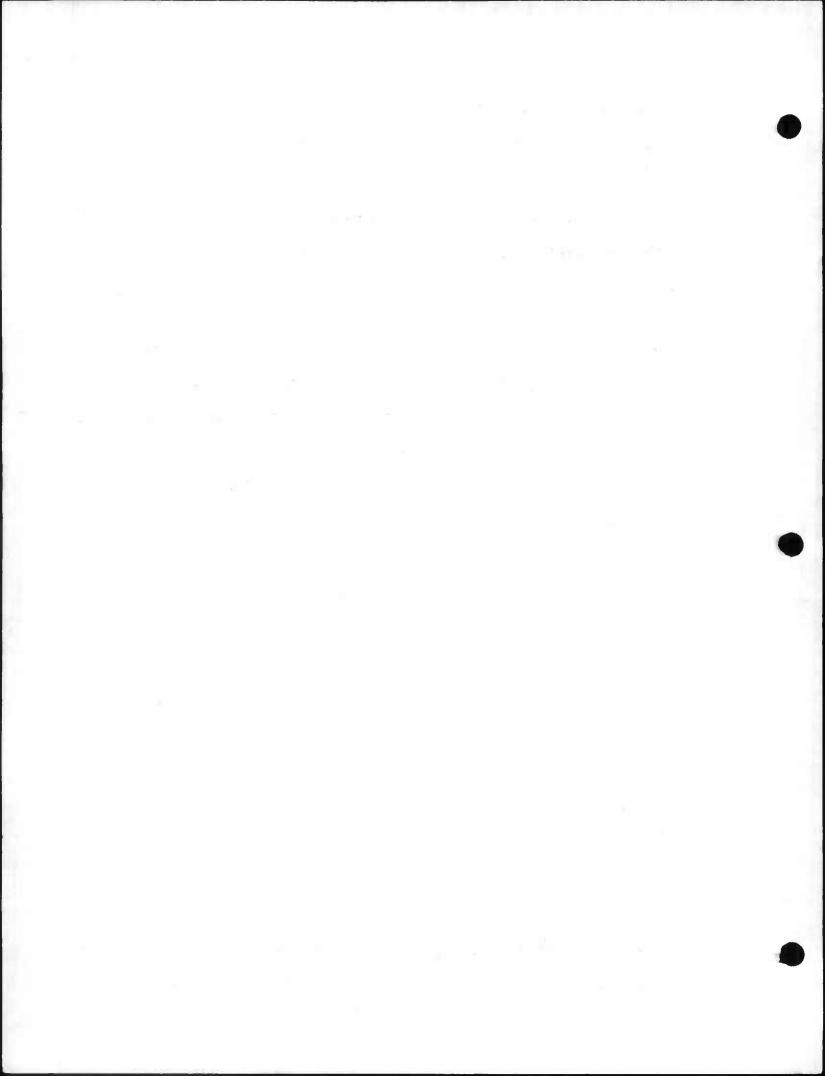
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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				Olato of W	arylana / i	Certificate			icinai i iy	Reg. No.	21	14/42	
	Physic /Medi		1. Decedent's Name (First, Middle, La.		ladefai	rri			2. Dale of De Month	eath Day	Year 1	3. Time of Death	
	Examir		4a. Facility Name (If not institution, give Holy Cross Ho	e street end number)				5. City, Town, or Lo		A 4	y of Death	omery	
	Funeral Director		N/A	ex 7. Ag	e (in yrs. lest bii	Yrs. If Under 1 Y	rear Pays	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di	rth ey, Year)	9. Birthp	place (Stale or Foreign htry) MD	
	Marylend a-f show	tor	Usual Residence of Decedent	omery	10c. City, Tow	m or Location Gaithers:	buı	rg			1	0d. Inside City Limits	
	23a or 28	Funeral Director	10e. Street and Number 17730 Topfield			10f. Zip Co		0877		10g. Citizen of U.S		itry?	
020	within 72 hours effer death with the Maryland ene. then "natural", or fems 23a or 28a-f show na Westerl Evans er must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		13. Was Decedent If Yes, specify			ecify Yes or No Rican, etc.)		ca - Americ ck, White, y: Bl	etc.	
2121 d within giene. or then		Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) N/A	ducation ide completed) College (1-4or !		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) N/A N/A						ss/industry	
Maryland ;	od of o	To Be C	17. Father's Name (First, Middle, Last) Shamsideen A.			**/		18. Mother's Name		, Meiden Sumer			
	nd 2 should and 27 is m	1	19a. Informant's Name/Relationship (Mailing Address (Si						MD 2087	
Baltimore,	t. Pages 1 rtment of He rtant: If iten		20a. Method of Disposition 133 Burial 2 Cremation 3 Care 4 Donetion 5 Other (Specify 21. Signature of Funeral Service Light	y)		f Disposition (Neme ory, cremetory or other of Heave	n (Cem. 4	Dete /28/	20c. Location			
Ba	Dermi Depe Impo any Ir		23a. Part1. Enter the Asease, or commence, or heart/spline. List only	Drow	d the deeth. Do ne.	ROCKVI	LLI	s of Facility FUNERAL E, MD g, such as cardiac	20850			Approximate Interval Between	
	Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting In death)	. Respi	ratory Due to for as e	Failure consequence of):						Onset and Deeth	
	bet nsit	Examiner		b. Extre		1	4				1	0 hours	
(09289)	rtificete be executed ng physician and s es the bunel-transit	ledicai	Sequentially list conditions, if any, leading to Immediate cause. Enler Underlying Cause (Disease or Injury that initiated events resulting In death) Last		consequence of):								
P.O. Box	requires that the death cer seen signed by the ettendir hould be deteched for use	Physician/N	Part II. Other significant conditions co	d	ut not resulting in	n the underlying caus	e give	n in Pert I.		tobacco use co		o the cause of deeth?	
Records,		Completed by								s an autopsy omed?	av	ere autopsy findings ailable prior to mpletion of ceuse death?	
Vital Re	The ate h	0	25. Was case referred to medical					26. Plece of Deet		Yes 2 No		Yes 2□ No	
of V	S S D	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpalie	eni 2 ER/Ou	utpatient 3 DOA	Othe	e.		Idence 6 Oth	ner (Specify	y)	
Division o	After fune	Certification:	27. Menner of Death 1 DNetural 5 Pending investigation 3 Suicide 6 Could not be		y Year) I	M		'es 2□No		how injury occur			
DIV			4 Homicide determined	building, et	c. (Specify)	ırm, sireet, factory, of			City or To	(Street end Numb wn, Stete)			
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	one) 2 Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination an	d/or investigation, in	my opi	inlon, death occurr	end due to the ed at the time,	date and placa,	and due to	the cause(s)	
	To You			Holdber				+5369		April			
			30. Name and address of person who of Alan K. Go. 31. Date filed (Month, Dey, Year)	ldberg 1	eath (Item 23e) MD s Signature	(Type, Print)	Fore	t5369 est Glav	Rd.	silver S	209 priv	10 19, MD	
	Sta Registr		APR 2 9	1997 ▶ 9	who David	son-Aandelle							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaar **Physician** Edward Horghan /Medical 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sun Ceci1 Calvert Manor Nursing Home Rising 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) if Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthpiaca (Stata or Foraign Country) **Funeral** 1 X M 2 □ F Months Days Hours 382-16-9023 Yrs. Director Sept. 4,1918 Detroit, Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits if than "naturel", or items 23a or 28a-f ehow the Medical Exeminer must be notified at PA Lancaster Millersville TX Yas 2 □ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? death with 2101 Wabank Rd. 17551 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 (∆Yas 2 □ No If Yas, Giva Year or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 11 Maritai Status 72 hours efter 1 ☐ Nevar Married 2 ☐ Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: white 2 3 □ Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) sub-contractor construction 12 should be filed w h end Mentel Hygier le merked other th 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be permit. Peges 1 and 2 should be Department of Health end Mente Important: If Item 27 le merked any Injury or other traumatic ev Anthony Abraham Anna Brotkey 2 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Nancy Krivanek 2103 State Rd., Oxford, PA 19363 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) R.A. Ferris & Co. 5/6 West Chester, PA 21. Signature of Funarai Sarvice Licensee 22. Nama and Addrass of Facility MD #123 Foulk & Gofus Funeral Home, Inc. West Grove, PA Part 1. Entar tha disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Onset and Death **Physician** /Medicai immediata Causa (Final diseasa or condition rasulting in death) Examiner Examiner DISEASE attending physician end for use as the burial-transit The lew requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Diseasa or injury that initiated evants rasulting in death) Last P.O. Box 68760, Physician/Medical Part it. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part it. 23b. Did tobacco use contributa to the cause of death? the Š 1 ☐ Yes 2 ☐ No 3 Cobably 4 Unknown signed I Records, þ 24b. Wara autopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed peen s page 2 s certificate 1 ☐ Yas 2 ☐ No Division of Vital Hospital or Attending Physicien: 24 hours after deeth. director, 25. Was casa referred to medical Be 28. Pjaca of Death (Check only ona) axaminar? 1 Yes 2 No Other: Nursing Homa 5 Rasidence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mennar of Death 28a. Deta of injury (Month, Day Year) 28c. tnjury at Work? 28d. Dascribe how injury occurred 28b. Tima of After 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant Director: 3 Suicida 6 ☐ Could not be detarmined 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 28a. Place of injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital of within 24 hours at To the Funeral D completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifiar 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) A of person who complated cause of death (Itam 23a) (Type, Print) Prine

32. Ragistar's Signatura

State Registrar 31. Data filed (Month Da

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Elizabeth Clagett Brown 30, 1997 4:00 PM April 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Silver Spring M If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Layhill Center Genesis Eldercare Network Montogmery 7. Age (In yrs. last birthdey) If Under 1 Year Montha Deys 5. Sociel Security Number Birthplace (State or Foreign Country) 1 ☐ M 2 🖫 F 80 579-30-1559 March 29, 1917 Washington, DC Usuet Residence of Decedant 10c. City, Town or Location 10a. Stete 10b. County 10d. tnside City Limits 1 ☐ Yes 2 XNo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13500 Rippling Brook Drive 20906 United States 12. Wea Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify 3 Ø Widowed 4 □ Divorced white Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Induatry Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Thomas Clagett Mary Elizabeth 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Same as 10 George F. Brown, Jr. 20b. Pieca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 5-6-97 Arlington, Virginia Arlington National Cemetery 22. Name and Address of Facility Rapp Funeral Services, P. A. 21. Signature of Funerel Service Licenses llen 933 Gist Avenue, Silver Spring, MD 20910 23a. Pert1. Enter the disaese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset end Death Immediata Cause (Finei disease or condition resulting in deeth) Metastatic Breast Cancer 3 months Due to (or ea e consequance of): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 1 ☐ Yes 2 No 25. Waa case raferred to medical axaminer? 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes \$\(\)\(\)\(\)\(\)\(\) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. injury et Work? 28d. Describe how injury occurred 1) (Neturel 2 Accident 5 ☐ Pending

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Be 2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

√2 Baltimore, Maryland 21215-0020

Examiner USB as 1 for page 2 director,

physician and the burial-transit requires that the death certificate be signed by the a d be detached f peen has certificate or Attending Physician: After this funeral after death. Director: Aft A h. In 24 house the Funeral Dire. Hospital 24 hours a

Records, P.O. Box 68760.

Division of Vital

þ Completed Be 10

3 Sulcide

29e. Certifier (Check only one)

4 Homicide

Physician/Medical Certification:

To the Hosp within 24 ho To the Fune completely fi 8

> State Registrar

Medical

29b. Signature and title of certifier akroai mo

investigetion

6 Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

D 24543

CX Certifying Physician: To tha best of my knowledge, deeth occurred at tha tima, data end place, and dua to the cause(s) and mannar as stated.

2 Medical Examtner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) end manner stated. 29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

May 1, 1997

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print) 3305 North Leisure World Blvd. James A. Rossi, M. D.

Silver Spring, MD 20906-1367

31. Dete filed (Month, Dey, Year) 32. Registrer's signature wie Davidson-Randelle 02 1997 ▶ MAY

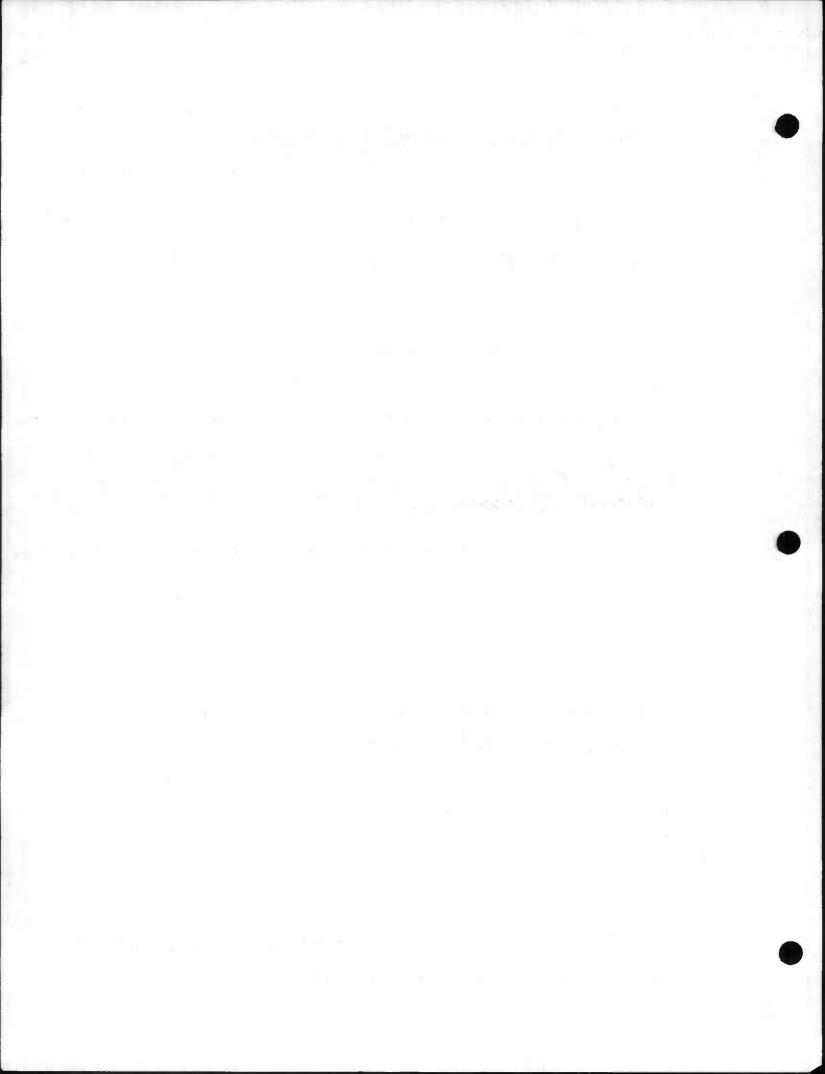
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene

97 14745

						Cert	ificate d	of Death			Reg. No.			
Г			1. Decedent's Name (First, Middle, I	.ast)					2.	Date of De	ath		3. Time of Death	
	Physic		REUBEN BONNETT						AT	Month PRIL 2	Day 24. 1997	Year 7	1:00PM	
	/Medi Exami		4a. Facility Name (If not institution, g	ive street and number)				4b. City, Tov				1117-11	1.001H	
			SHADY GROVE A			PITAL			VILLE			TGOME	RY	
	Funeral Director		5. Social Security Number 6. 578-01-3681 Usual Residence of Decedent	Sex 7. Ag	ge (In yrs. last.	Yrs.	If Under 1 Ye Months Da		Min.	Date of Bir (Month, Da)8/27/	th ly, Year) 1915	9. Births Cour MARYI	place (State or Foreign http) LAND	
	yand war		10a. State 10b. County		10c. City, To	own or Loca	ation					1	10d. Inside City Limits	
	Mar	to	FLORIDA BROWARD		BOCA R	ATON							1 ☐ Yes 2 No	
	or 28	Director	10e. Street and Number				10f. Zip Cod	е			10g. Citizen of What Country?			
	23a		5800 CAMINO DEL	SOL SUITE	#407		33433			USA				
	tem tem	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent Yes, specify C	of Hispanic Origination, Mexican,	in? (Specific Puerto Ric	y Yes or No		ce - Americ		
Maryland 21215-0020	in 72 hours after death with the Maryland "natural", or items 23s or 28s-f show redical Exemitres must be notified at	by	1 ☐ Never Married 2 New Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	1 ☐ Yes 2 ♣No If Yes, Give 1 ☐ Yes 2 ♣No Specify: Spec Year or Dates:						Speci	y: WHI	TE	
5	72 h	Completed	15. Decedent's (Specify only highest of	Education rade completed)	16	(Give k	nt's Usual Oc	ne durina most	of working		16b. Kind of E	Business/In	dustry	
12	filed within Hygiane. ther than "	Ig I	Elementary/Secondary (0-12)	College (1-4or !	College (1-4or 5+) 3 ATTORNEY LEG						1 7011			
0 0			17. Father's Name (First, Middle, La	3	A	TTUKN	EY	18. Mothar	r's Nama /F	irst. Middle	LEGAL Maiden Sumai	me)		
lan		To Be	MORRIS BONNETT	•				DORA				,		
ary	d 2 should be th and Menta 7 is marked i traumatic ev		19a. Informant's Name/Relationship	(Type, Print)	1	9b. Mailing	Address (Str	eet and Number	r or Rural R	loute Numb	er, City or Town	, State, Zip	Code)	
Σ,	D = V =		MILDRED RUBEN BO	NNETT/WIFE	5	800 C	AMINO :	DEL SOL	, SUI	TE#40	7, BOCA	RATO	N, FL 33433	
ore	of Healt filem 2		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	20b. Place came	of Disposi itery, crema	tion (Name of atory or other	place)		Date	20c. Location	- City or To	own, State	
E	ment tant:		4 Donation 5 Other (Spec	ify)	JUDE	AN ME	MORIAL	GARDEN	S 4/	27/97	NORBEC	K, MA	RYLAND	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.	_	21. Signatura of Funeral Service Me	ensee /		22. DA	Name and Ad NZANSK	dress of Facility	ERG M	EMORI	AL CHAP	ELS,	INC.	
	TO Z & G	(tanh !	Wym	el	11	70 ROC	KVILLE	PIKE,	ROCK	VILLE, 1		AND 20852	
	Physician /Medical Examiner		23a. Part1. Enter the diseasa, or co shock, or heart faliura. List on Immadiate Cause (Final disease or condition resulting in death)					dial					Approximata Interval Between Onset and Death	
		Je.	resulting in death)		Due to (or as	a consequ	ence of):						- 13	
20,	certificata be executed ding physician and use as the burial-transit	i Examiner	Causa (Disease or injury that initiated events c. Due to (or as a consequence of):											
ox 68760,	leath cerificata b attending physic d for use as the t	//Medical												
80	death atter	iclar	Part ii. Other significant conditions	contribution to doub b	ut not requiting	- In the use	to the course	nium in Boot I		nah Mid	tobosco uso o	and of the state of	a the sauce of death?	
P.O.	iras that the death signed by the atte d be datached for	/ Physiclan/						given in Part I.		少	¥es 2□ No		o the cause of death? bably 4 ☐ Unknown	
Division of Vital Records,	aw requisite been 2 should	Completed by	Congesti	re hear	of fo	ailu	79				an autopsy ormed?	alv co	ere autopsy findings vailable prior to empletion of cause death?	
<u> </u>		Con								1 🗆	Yes ZINO	1[☐ Yes 2☐ No	
113	certificata rector, pag	Be	25. Was casa raferred to medical examinar?						of Death (C	Check only	one)			
5	Physician: this certific ral director,	ပို	1 Yes 2 No	Hospital:	-	Outpatient	SEI DON				danca 6 □Ot		'y)	
ב	After funer	ioi	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) 28b	D. Time of Injury		njuryat Work? I∐Yes 2∐N		J. Describe	how injury occu	rred		
JIVISIO	f or Attanding after death. Director: After d in by the fune	Certification:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 390 Place of Ini	ury - At home, c. (Specify)	farm, stree				Location (ber or Rure	al Route Number,	
	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical Co	29a. Certifiar 1 Certifying F (Check only one) 2 Medical Exe	hysician: To the bast of minar: On the basis of and manner sta	axamination a	ige, death o and/or inva	occurred at the stigation, in m	e time, date and ny opinion, deat	d place, and h occurred	I due to the at the tima,	cause(s) and m date and placa	anner as s	tated. o the cause(s)	
	To the	Me	29b. Signature and title of certifier	mayor	7			ense number 479	03		29d. Date algni			
	80		30. Nama and addrass of person who complated causa of death (Itam 23a) (Typa, Print) FRANCIS C. MAYLE, 10215 FERNWOOD ROAD, BETHESDA, MARYLAND											
	Sta	te	31. Data filed (Month, Day, Year)	20 Paginte	ada Cinnatura									
	Regist			2 8 1997	ars signatura	Davidson	n-Agndal	2						
DHE	4H 16 Day 6/0	6			V _									

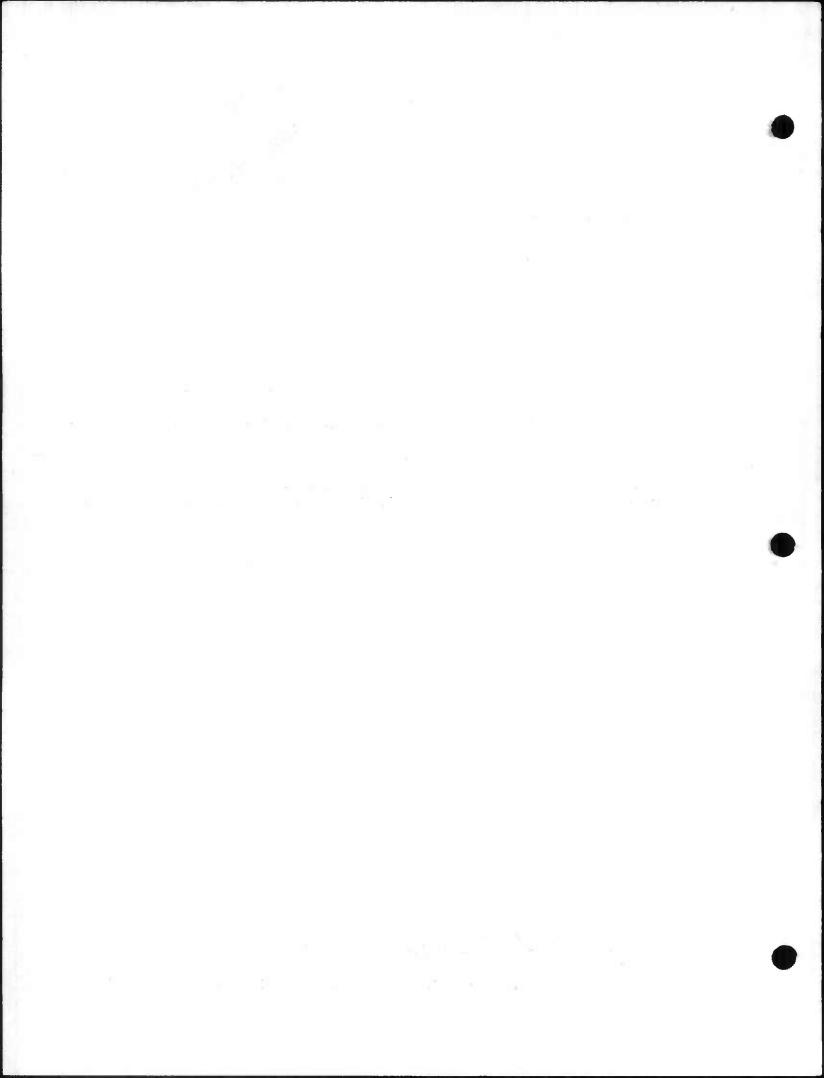
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

14746

						Cei	tificate of	Death		Reg. No.		
	Physic /Medi		1. Decedent's Name (First, Middle, La Gertrude	М.		Bow	en		2. Date Appro	of Death	997 Yeer	3. Time of Death 10:05 PM
À	Examir		4e. Facility Name (If not Institution, giv 11315 Rolling Ho					46. City, To Rockvi	wn, or Location of		ounty of Death In Egome r	У
	Funeral Director		390-22-0229	ex	Age (In yrs. le 92	st birthdey) Yrs.	If Undar 1 Yaar Months Days		24 Hrs. 8. Data Min. (Mon Septe	of Birth th, Dey, Year) EMDER 4, 1	9. Birth Gou 904 GE	placa (Stete or Foreign ntry) PMany
	death with the Maryland ms 23a or 28a-f show critisat be notified at	ector	Usual Residence of Decedant 10a. State 10b. County Maryland Montgome	ery		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with the part of t	Dire	10e. Street and Number 19310 Clubhouse Ro	and #110)		10f. Zip Code 20879				n of What Cou ed Stat	•
020	72 hours after death with the Marylar "satural", or Items 23e or 28e-f show edical Exarriner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yas 24 if Yes, Give Yaar or Data	nt Evar in U,S \$? YNo	. 13. V		Hispanic Ori oen, Maxicar	gin? (Specify Yas i, Puerto Rican, at	or No- c.)	Race - Amari Black, Whita,	can indian,
*Baltimore, Maryland 21215-0020	within then to Man	Completed	15. Decedent's Ec (Specify only highest gra Elamentary/Secondary (0-12)	ducation ide completed) Coilege (1-4c		16a. Deced (Give life. L	lent's Usuai Occu kind of work done DO NOT use ratin	pation during mos ed)	t of working	16b. Kind	of Business/Ir	dustry
yland 2	Mental Hygi wheel ather atic event, II	To Be C	17. Father's Name (First, Middle, Last, John Hillmer						ors Name <i>(First, A</i> usta Grie		umeme)	
Mar	Health and I sho Health and Hem Z7 is the other traums		19a. informant'a Name/Relationship (Donald Richard Bo		1				er or Rural Route Road, F			code) Vland 20852
imore	Pages ent of nt: If it		20a. Method of Disposition 1 Buriai 2 Cremation 3 4 Donation 5 Other (Specific		te cer	netery, cren	sition (Name of natory or other pla ke Crema		Date 4-25-9		sville,	own, Stata Maryland
Balt	permit. Page Department of Important: If any injury or sense.		21. Signature of Funeral Sarvice Licer	DoQ.					e, Silver		, Maryl	and 20910
	Physician /Medical Examiner		23a. Part1. Enter tha disease, or com shock, or haart failure. List only tmmediata Causa (Final disease or condition rasulting in death)		iratory		ure	ing, such as	cardiac or respira	tory arrest,	1	Approximate interval Between Onset and Death
•	executed n end al-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. CVA	Dua to (or a	as a conseq	uence of):	·		·		several wee
ox 68760,	certificate be executed nding physician and use as the burlal-transit	VMedical	Cause (Disease or injury that initialed events rasulting in death) Last	d	Due to (or a	ts e consequ	uanca of):	, , , , , , , , , , , , , , , , , , , ,				
m	death	sicia	Part II. Other significant conditions of	ontributing to death	but not result	ing in the un	deriving cause g	van in Part i	23h	Did tobacco us	e contribute t	o the cause of death?
s, P.O.	requires thet the death ween signed by the ette hould be detached for	by Physician										bably 4 \ Unknown
Division of Vital Records,	aw requir	Completed				-			24a	. Was an autopsy performed?	av	are autopsy findings railable prior to empletion of cause death?
a B	: The law icate has b									1 Yes 2	No 1	Yas 20 No
Ĭ	sician: The certificate lirector, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospitai: 1 ☐ Inpa	dient OFF	R/Outpatien	t 3□ DOA OI	hor	of Death (Check	1/	700000000000000000000000000000000000000	syson's home
ion of	To the Mospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		27. Manner of Death 1 0 Natural 5 Panding 2 Accident invastigation	28a. Date of tr (Month, L		8b. Time of injury	28c. inju	4 L Nu	28d. Des	cribe how injury o		y/son s none
Divis	tal or Attend is after death af Director: /	Certification:	3 Suicide 6 Could not be determined	288. PIRCE OF	injury - At hom etc. (Specify)	e, farm, stre	eet, factory, office			tion (Street end Por Town, Stele)	Number or Run	al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edlcai	29e. Cartifier (Check only one) 1 Certifying Ph	ysiclen: To the besinner: On the basis end manner	of examinatio	edga, death n and/or inv	occurred at tha t estigation, in my	ime, date an opinion, dea	d piace, and due t th occurred at the	o the causa(s) an time, dete and pi	nd mannar as a ace, and due t	stated. o the cause(s)
	/	×	29b. Signature and title of fertifier	Da	cam.	0	29c. Lican				algned (Month,	
	5		John S. Saia, M.D.					Rock	ville, M	aryland	20851	
	Sta Registr		31. Deta filed (Month, Dey, Year) APR 2	8 1997	Strer'a Signatu	Davidson	n-Mandell					V - 3



State of Maryland / Department of Health and Mental Hygiene

97 14747

						Cert	ificate of	Death		В	Reg. No.	21	14/4/	
	Dhari		1. Decedent's Name (First, Middle, La	ist)						Date of Dea	ith	М	3. Time of Death	
	Physic /Medi		Newbill G. Black	k						Month April			10:00 PM	
	Exami		4a. Facility Name (If not institution, given	ra street end number)				4b. City, Tow						
			616 Blick Drive					Silver	r Spri	ing	Monts	gomery	y	
	Funeral Director		5. Social Security Number 6. 9 578-05-2746 Usual Residence of Dacedent	Sax 7. Age	95	thday) Yrs.	If Undar 1 Yea Months Days		Min.	Date of Birth (Month, Dey ept 6,	7, Year) 1901	9. Birthpl Count Virg	lace (Stete or Foreign try) 3 ini a	
	/land		10a. State 10b. County		10c. City, Town	n or Loca	ation					10	0d. Inside City Limits	
	Man	호	Maryland Montgo	nery	Silve	er S	pring						1 ☐ Yes 2 No	
	or 28	Director	10e. Street and Number				10f. Zip Code			1	10g. Citizan of	What Count	try?	
	23a		616 Blick Drive				2	0904			USA			
	r dea	Funerai	11. Marital Status	12. Was Dacadent E Armed Forcas?	Ever in U,S.	13. W	as Dacedent of Yes, specify Cu	Hispanic Origi	n? (Specify Puerto Rice	Yes or No-	14. Rac			
21215-0020	ours afte	b	1 Never Married 2 Married	1 ☐ Yes 2 🛣 N If Yes, Give Year or Dales:	lo		□Yes 2【XNo					Day Yaar 24, 1997 10:00 P 4c. County of Death Montgomery Year) 9. Birthplace (State or Foreit Country) 1901 Virginia 10d. Inside City Limit 1 Yes 2 N N 14. Race - American Indian, Black, Whita, atc. Specify: White 6b. Kind of Business/Industry Retail aiden Sumeme) 6c City or Town, State, Zip Code) MD 20904 0c. Location - City or Town, State Suitland, MD di Funeral Home .1ver Spring, MD 209 st, Approximate Inlerval Between Onsat and Death Years Approximate Inlerval Between Onsat and Death Years 2 No 3 Probably 4 Unknown autopsy findings available prior to completion of ceuse of death? 2 No 1 Yes 2 N No 1 Yes 2 N No		
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2	Should Me mark mark	2	19a, Informant's Name/Relationship (19b	Mailing	Address (Stree					State Zin	Code)	
2	s 1 and 2 should f Haalth and Mor tem 27 is marke other traumatic	ł	Andrew Deremer/										0000)	
altimore,	permit. Pages 1 and 2 s Department of Health ar important: If Item 27 is any Injury or other trau once.		20a. Method of Disposition		20b. Place of	Disposi	tion (Neme of story or other pl	0001	D	ate	20c. Location	- City or Tox	wn, Slate	
Ë	Page nent of rry or		1 N Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				1 Cemet	,	Apr	30	Suit1a	and. M	(T)	
<u>a</u>	mit. partm porta y Inju		21. Signature of Funeral Service Licer	isee		nes-Rinaldi Funeral Home								
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	Physician	E O	23a. Pert1. Enter the disease, or com shock, or heart failure. Est only	plications that ceused one cause on each lin	the death. Do n	not antar	the mode of dy	ring, such as co	erdiac or ras	spiratory arr	est,		Approximate Interval Between Onsat and Death	
	/Medical Examiner		Immediate Causa (Final disaase or condition	Arter	ioscler	otic	Heart	Diseas	е				Years	
	Examiner		resulting in death) Due to (or as e consequence of):											
	be sit	Examiner		b										
	icate be axecuted physician and s tha burial-transit	xan	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury		Due to (or as a c	conseque	ence of):							
68/6U,	sician sician		ceuse. Enter Underlying Cause (Diseese or injury that Initiated events	C								i		
0x 68	death certificate be axecuted e attending physician and nd for usa as tha buriai-transit	n/Medical	resulting in death) Last	d	Oue to (or as a c	onseque	ence or):							
ă	d for a	Physician	Part II. Other significant conditions o	antributing to death but	t not soculting in	Alban samul	la shaka a a sa sa sa	han la Dari I		not blake			No. of the Control of	
5	tha y th ache	hys				ine und	enying cause g	iven in Part f.						
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Records,	law requires that tha as been signed by th 2 should be datache	Completed							1-40	24a. Was a perform		ava	llable prior to npletion of ceuse	
	0 - 0	E								1 🗆 Ye	es 210 No	10	Yes 21X No	
VITAI	certificate	Be	25. Wes case referred to medicel					26. Place o	of Death (Ch	eck only on				
0	Physician: this certific ral director,	To	examiner? 1 ☐ Yes 2 ∑ No	Hospital: 1 Inpatier	nt 2 ER/Out	tpetient	3□ DOA O	thor				er (Specify)	
	ttending Ph death. ctor: After th y the funeral		27. Manner of Deeth 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28e. Dete of Injur (Month, Dey		ime of njury	28c. Inju Wo	uryat ork?]Yes 2 □ No		Dascribe ho	ow injury occur	red		
DIVISION	rei in	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		ry - At home, far (Specify)	rm, strea			28f. l	Location (St City or Town	treet end Numb n, Stete)	per or Rural	Route Number,	
	To the Hospital or within 24 hours after To the Funeral Dir completaly filled in	edicai C	29a. Certifier (Check only one) 1 ★ Certifying Ph	ysician: To the best of niner: On the basis of end manner stat	examination and	, death o	occurred et the t stigetion, In my	ime, date and oplnion, death	place, and o occurred at	due to the ca the time, d	ause(s) end me ete and place,	enner as sta end due to	ated. the ceuse(s)	
	within To th comp	Me	29b. Signature and title of certifiar	0			29c. Lican	sa number		2	9d. Date signe	d (Month, D	Jay, Year)	
	1		1 antur &	S. O Gres	2-		D	04418			April 2	25, 19	997	
	3		30. Name and eddress of person who			* .		0.11			Von 1	-1 0	0001	
		40	Arthur S. Bresle 31. Dele filed (Month, Day, Year)					e, S11V	er Sp	ring,	maryla	na 2	0901	
	Sta Registr		APR 2 S	32. Registra	wha David	lson-i	Andell.							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended #7, 4/29/97, JW, Mont. Ctv. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth April Dey 1997 Year **Physician** 25, 12:00 AM Maria Batson /Medical 4b. City, Town, or Location of Death 4a. Fecility Neme (If not Institution, give street and number) 4c. County of Death Examiner 8712 Colesville Road #108 Silver Spring Montgomery 7. Age (In vrs. lest birthdey) If Under 1 Yeer If Under 24 Hrs. 5. Sociei Security Number Birthplece (State or Foreign Country) **Funeral** 1□M 2X F Deys Hours 102 Yrs. Director 579-50-7921 January 20, 1895 Venecuela Usuei Residence of Decedent 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumetic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Directo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zlp Code 10g. Citizen of Whet Country? 8712 Colesville Road #108 20910 Venecuela Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours aftar of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or her any injury or other traumatic event, the Medical Examinat 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yas 2 ☐ No þ Specify 3 □ Widowed 4 □ Divorced Venecuelan White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) dress maker own business 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be Francisco Rios Fermina Merentes 0 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 8712 Colesville Road #108, Silver Spring, MD 20910 Jose Miguel Batson son 20b. Piece of Disposition (Name of cametery, cremetory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 D Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven 4-30 Silver Spring, Maryland 21. Signeture of Funerei Servica Licensee 22. Neme end Address of Fecility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immedieta Causa (Finel Cardiopulmonary Arrest disease or condition resulting in daeth) Examiner Due to (or es e consequence of) Examiner Atrial fibrillation 2 months Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted evants resulting In death) Last Due to (or as e consequence of): Cardiomyopathy 1 year Physician/Medical Due to (or as e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yss 2 X No 3 Probably 4 Unknown þ 24b. Ware eutopsy findings available prior to complation of cause of death? Completed 24a. Wes en eutopsy performed? page 2 1 Yes 2 No 1 Yes 2 No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 A Residence 8 Other (Specify) 2 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury et Work?

attending physician and for use as the burial-transit that the death certificate be axecuted Box 68760. signed by the atter Division of Vital Records, P.O. should t certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, s

the Maryland

Baltimore, Maryland 21215-0020

Certification:

27. Menner of Death 1 Naturai 2 Accident

29a, Certifier

3 Suicide 4 - Homicide

5 Pending invastigetion 6 Could not be determined

28e. Dete of injury (Month, Dey Year)

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28b. Tima of

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) The Certifying Physician: To the best of my knowledga, daath occurred et the time, date and piace, and due to tha causa(s) and manner as stated.

2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred et the time, date end piace, and dua to the causa(s) end menner stated.

29b. Signature age title of certific

29c. License number

D31326

29d. Date signed (Month, Dey, Year)

30. Nema end addrass of person who completed cause of death (item 23a) (Type, Print)

Richard B. Ashby, M.O., 12164 Central Avenue, Bowie, Maryland 20721 31. Dete filed (Month, Dey, Year)

State Registrar

in by tha

Medical

32. Registrers Signeture **APR 29** ia Davidson . . .

Plea

P	ease 1								II Copies		egible	7	14749
tem:1per Phys	ician	G-747	5/29/	97 (Pertificat	te o	f Death			Reg. No.			
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Jando	rd	SAN	FORD		Ī	0	nke	er	April	ක්	199	7	8:20 pm
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Suburban Ho 5. Sociel Security Number	spita	1	7. Age (In yrs	s lest hirthi	day) If Unde	r 1 Ye		thes	8. Dete of B		ontgo		ce (State or Foreign
152-24-8435	**	M 2 F	66	Υr	Months	De		Min.	(Month, D	e <i>y, Year)</i> h 19 , 1		Country	r)
Usual Residence of Deceden	t								Marc	11 19,1	1931	1	New York
10e. Stete 10b. Co.	unty		10c. C	ity, Town o	or Location							100	I. Inside City Limits
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10e. Street and Number					10f. Zip	Code	9			10g. Citize	n of What	Country	/?
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1 Never Merried 2 3		Armed Fo 12 Yes If Yes, Giv Yeer or Da	2 No	-54	If Yes, spe				pecify Yes or N Rican, etc.)		Bleck, W		c.
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Arthur	Ban	ker					H	eler	1	Schatt	en		
19e. Informent's Neme/Relet	onship (Ty	pe, Print)		19b. N	Mailing Address	s (Stre	et end Numb	er or Rui	ral Route Numi	ber, City or T	rown, Stat	e, Zip C	ode)
Scott Banker	/ Son				14705	Chi	sho1m	Land	ling Wa	v. N.	Poto	mac	Md. 2087
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21. Signeture of Funeral Sen	ice License	96					dress of Fecili						1000
19/11					Edward 1091 Re	Sa	gel Fu ville	nera Pike	Rockv	ection	MD.	2085	52
23a. Part1. Entar the disaase shock, or heert feilure. Immediete Causa (Final disease or condition	, or compti List <i>on</i> ly on	cetions that co	eusad the desert line.	ath. Do not	enter the mod	de of c			or respiretory			lr.	pproximete htervel Batween Onset end Deeth
rasulting in deeth)	а		Due to	(or es e co	nsequence of):								
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Cause (Disease or Injury that Initiated events rasulting in deeth) Lest			Due to (or es e cor	nsequence of):								
	- 0	. —										1	
Pert II. Other significant con-	itione con	tributing to de	ath but not re	sulting In th	ne underlying o	ause	given in Pert I).	23b. Did	l tobacco us	e contrib	ute to ti	he cause of death?
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										s en eutopsy ormed?	, 24	evella	e eutopsy findings able prior fo pletion of cause ath?
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exeminer? 1 Yes 2 No	Н	ospital:	npatiant 20	☐ ER/Outpo	etient 3 DC	DA	Other:		ome 5 Res		Othar (S	pecify)	
27. Manner of Death Naturel 5 Par 2 Accident inv	nding estigation	28a. Date o	-	28b. Tim Inju		28c. In	ijuryet Vork? □Yes 2□		28d. Dascribe				
3 ☐ Suicide 6 ☐ Co	uld not be armined	28e. Plece buildin	of Injury · At I	nome, ferm	, street, fector	y, offic	Çe .		28f. Location City or To	(Street end I own, Steta)	Vum <i>ber</i> or	Rural F	Route Number,

Baltimore, Maryland 21215-0020 **Physician** /Medical **Examiner**

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mantal Hydiens. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercise must be notified at once.

Physician /Medical

Examiner

Funeral Director

Director Md.

Funeral

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Completed

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Examiner

Physician/Medicai

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Completed

Be 10

Certification:

Medical

29a. Certifier (Check only one) 29b. Signeture end title of Can

been signed by the attending physician end should be deteched for use as the buriel-trensit page 2 hes

The law requires that the death certificate be executed After this certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica director, filled in by the funeral

Division of Vital Records, P.O. Box 68760,

12 12

State Registrar

30. Neme and eddress of person Who completed ceuse of deeth (Item 23a) (Type, Print) Dr. F. Smith

D33 293

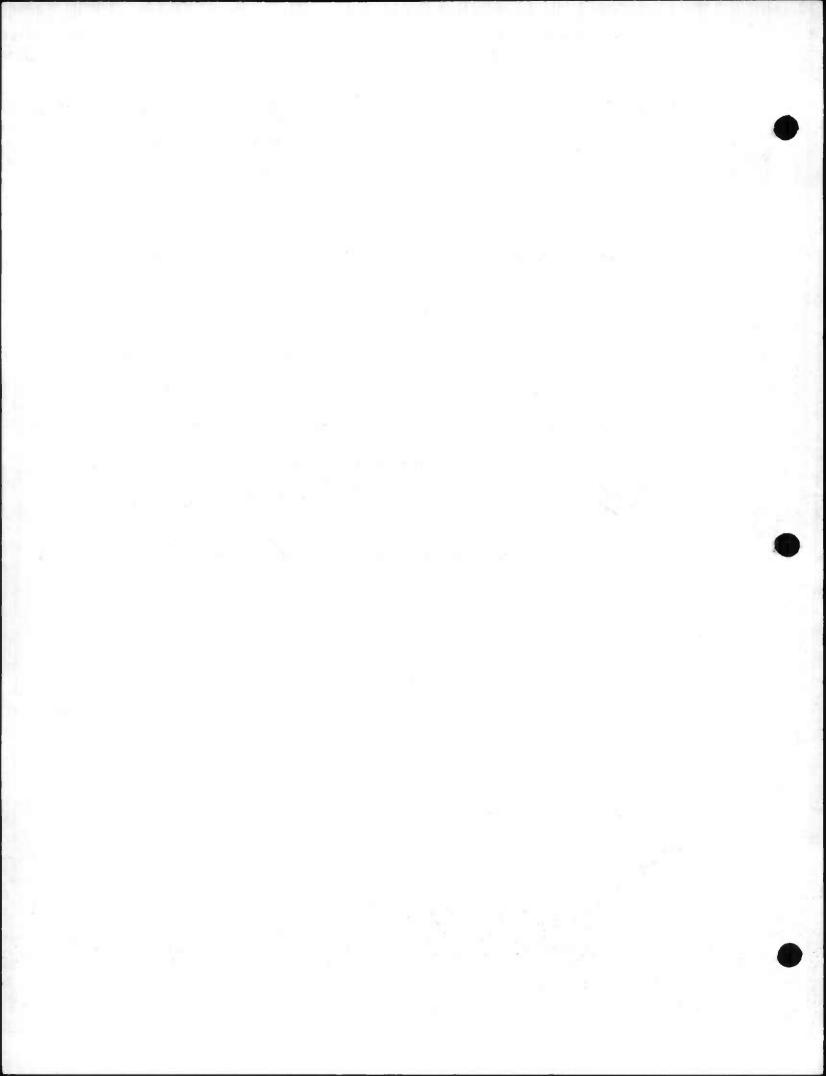
12 Certifying Phyelcian: To the best of my knowledge, deeth occurred et tha time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred et the time, date end piece, end due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

5401 Western Ave NW Wash. DC 20015

31. Dete filed (Month, Dey, Year) wha Davidson APR 25



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1997 **Physician** Month April 24, 5:15 A.M. Carolyn Anne Beck /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10808 Stanmore Drive Potomac Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□ M 20 F Days Hours 035-24-7335 61 Yrs. 1935 Providence RI Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Montgomery Potomac 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10808 Stanmore Drive 20854 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ② No Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Raca - American Indian, Black, Whita, etc. 1 Naver Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White by 3 Widowed 4 Divorced Yaar or Datas: Completed 15. Decedent's Education (Specify only highast grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be Clarence H. Rison Ebba I.E. Rydberg 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Alan A. Beck Husband 10808 Stanmore Drive, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuriai 2 ☐ Cremetion 3 ☐ Removel from State Swan Point Cemetery 4/29/97 Providence, RI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Lloy 22. Name and Address of Facility Joseph Gawler's Sons, Inc 5130 Wisconsin Ave., NW, Washington, DC 20016 or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, in JLIst only one cause on each line. ntarval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Due to (or es e consequence of): Examiner Arteriosclerotic Heart Disease Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting In deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Chronic Pulmonary Disease 1 Tyee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior fo Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yas 2 ☐ No Be 25. Was casa referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖾 Residenca 6 ☐ Other (Specify) 2 1⊠Yes 2□ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 18 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and plece, end due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifiar 29d. Date signed (Month, Day, Year) 29c. License number D01665 April 24, 1997 30. Name end address of person who completed cause of death (Ifam 23a) (Type, Print) 5530 Wisconsin Ave., Chevy Chase, MD 20815 Suite 1400 Robert Flynn, M.D.

32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

APR 28 1997

Funeral

Director

r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at

the Marylend

filed within 72 hours efter deeth with

al Hygiene.

i. Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: if item 27 is marked other th jury or other traumatic event, to

permit. Page Depertment of important: If any injury or

Physician

/Medical

Examiner

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page 2 should

this certificate has

rapital or Attending Physician: The hours after death.

Ineral Director: After this certificet y filled in by the funeral director, px

To the Hospital within 24 hours a To the Funeral Completely filled Hospital

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and

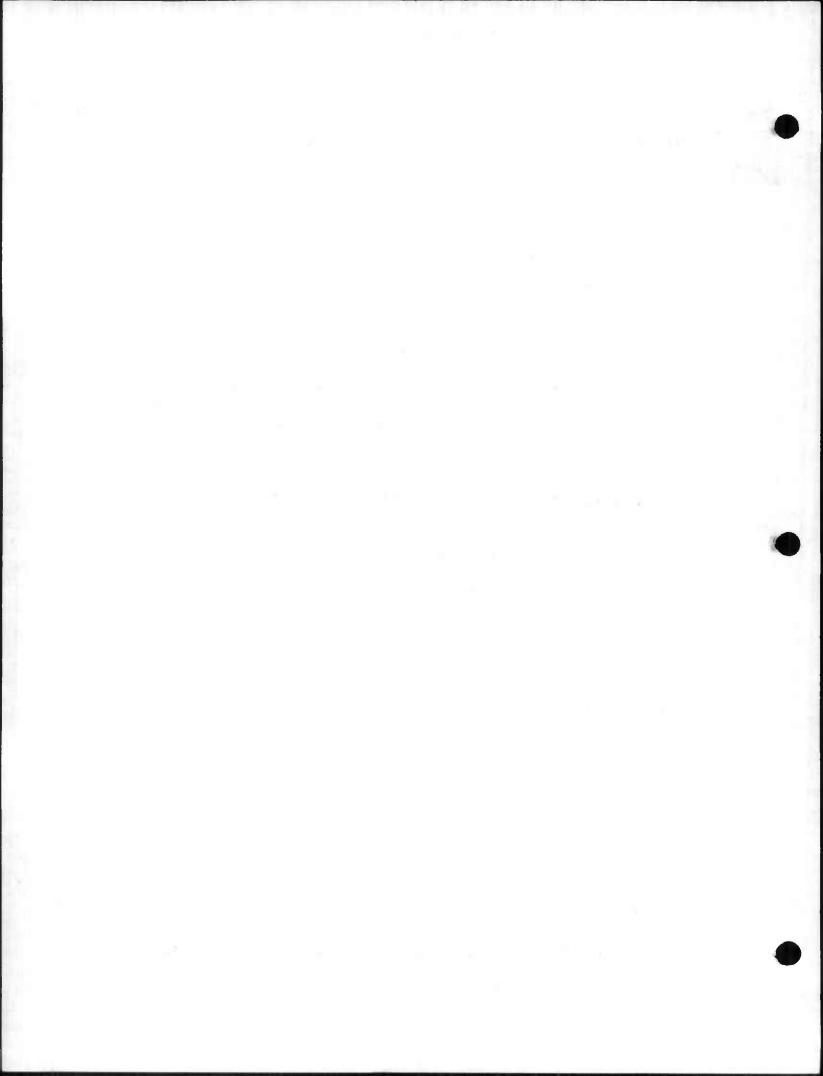
The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

21215-0020

Baltimore, Maryland

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death **Physician** Month Year BERNARD R. BROOKS 1997 April 23 9:11 PM /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Lanham
If Under 24 Hrs. 8. Date of Birth
(Month, Day, Prince Georges Doctors Community Hospital If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2 F Days 54 Yrs. 579 52 9404 Director AUG 10 1942 WASH. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2 □ No Director P.G. MD. LANHAM herris 23a or 28a-f ner must be notifie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5406 ARNOLD DRIVE 20706 USA Funeral 11. Marital Status 12. Was Decedenf Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1)X Yes 2 □ No If Yes, Give Year or Dates:60/63 1 Never Married 2 Married 6 1 Yes 2 No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grada complated) COMPUTER TECHNICIAN Elementary/Secondary (0-12) College (1-4or 5+) PVT. 12 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maidan Surnama) MITCHELL BROOKS ROSE CARROWAY 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) of Health : If Item 27 i 5406 ARNOLD DR. LANHAM MD. 20706 MATTIE BROOKS/WIFE 20b. Piace of Disposition (Nama of cematary, cramatory or other place)

MD. STATE VETERANS CEM. 4/30/97 CHELTENHAM, MD. 20a. Method of Disposition Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service License 22. Name and Address of Facility WATSON F. H. INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdlac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Bety Onset and Deeth **Physician** /Medicai Immediate Ceuse (Final Cardun Anest disease or condition resulting in death) Examiner Examiner Cancer of Live physician and the burial-transit certificata be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Last Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23h. Did tohecco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Onknown g 24a. Was an autopsy performed? 24b. Ware eutopsy findings available prior fo Completed peed completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicet examiner? Be 26. Plece of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Naturat 1 Yes 2 No 2 Accident

Records, P.O. Box 68760 Division of Vital

BEKNARD BRO

After he Hospital or Attending in 24 hours after death. he Funeral Diractor: Afte

To the Within 2 To the

State Registrar

Medical

3 Suicide

29a. Certifier

4 Homicide

29b. Signature end title of certifier

Kenun MD

6 Could not be determined

29c. License number

Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

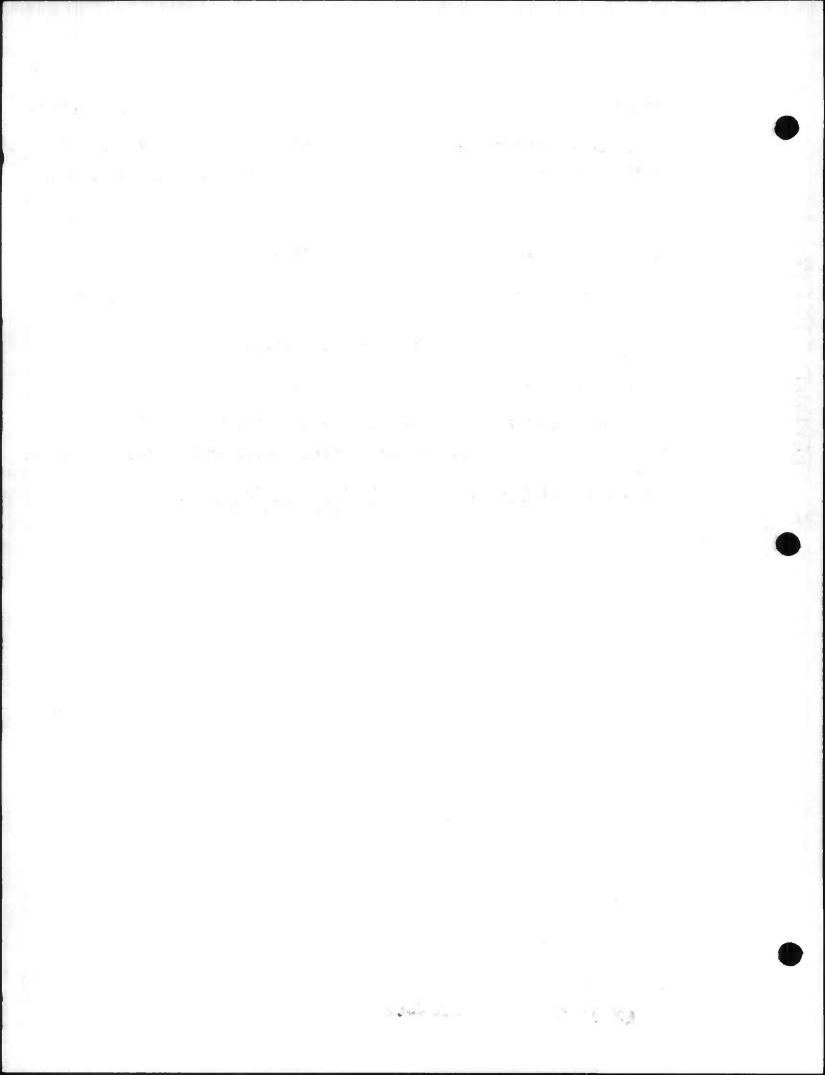
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
STEVEN REMSEN, MD CEA 575 MAIN STREET, SUITE 355, LAUREL MD

31. Dete filed (Month, Day, Year) APR 29

32 Registrar's Signeture

28e. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene

14752 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath **Physician** 20:25 Mac William Charles Bishop, Sr. /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital of Cecil County Elkton Cecil If Undar 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, Birthplaca (Steta or Foraign Country) **Funeral** Deys 1**X** M 2□ F Hours Director Yrs 236-52-1094 63 Aug. 3, 1933 West Virginia Usual Rasidance of Decedent the Maryland 10a. Stata 10b County 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f should be noticed at Director 1 ☐ Yas 2 No Maryland Cecil Elkton 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 10 Leedom Road 21921 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 X Yes 2 □ No If Yas, Give Yaar or Datas: 52-56 Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Marital Status traumetic event, the Medical Examiner. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 6 1 ☐ Yas 2 💢 No Specify: PV Specify: White 3 Widowad 4 Divorced "natural", Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education 16b. Kind of Businass/Industry (Spacify only highast grada complated) permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If flem 27 is marked other than any Injury or other traumerin. Elementery/Secondary (0-12) Collaga (1-4or 5+) Press Operator Metal Fabrication 12 17. Fether's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumeme) William M. Bishop Letha Ethel Akers 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) Blanche C. Bishop - Wife 10 Leedom Road - Elkton, MD 20b. Placa of Disposition (Nema of camatary, cramatory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 5-6 1 ☑ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Union Cemetery 1997 Union, Maryland 22. Nama and Addrass of Fecility Hicks Home for Funerals, P.A. 21. Signetwra of Funarai Service Licansaa 103 W. Stockton Street - Elkton, MD 21921-5521 23a. Part1. Entar tha disaase, or complications that caused tha daath. Do not enter the mode of dying, such as cardiec or respiretory errast, shock, or haart failura. List only one cause on each line. Onset and Daath **Physician** /Medical Immediete Causa (Final disaasa or condition resulting in daath) Examiner Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to Immadiate causa. Enter Undarlying Ceusa (Disaasa or Injury that initieted avants resulting in daath) Last end Box 68760. ettending physician for use es the buria Physician/Medical the P.O. signed by the d Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Drobably 4 Unknown þ 24b. Wara autopsy findings evellabla prior to complation of ceusa of deeth? Completed 24a. Was an autopsy performed? pege 2 s certificate 1 Yas 2 NO 1 Yas 2 No Be 25. Was casa rafarred to madical 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 PR/Outpatient 3 DOA of this funeral 27. Manner of Death 1 Meturel 28a. Data of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred Attending After 5 Panding invastigation 1 ☐ Yas 2 ☐ No death. 2 Accidant Director: / 3 Sulcida 6 Could not ba 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 28e. Plece of Injury - At homa, farm, streat, factory, office building, etc. (Specify) or A efter 4 Homicida To the Hospital of within 24 hours of To the Funeral Discompletely filled 19 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, dete and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of exeminetion end/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Cartifier 29b. Signal 29c. Licansa number 29d. Dete signed (Month, Day, Year) Q+IVK of deeth (Item 23a) (Type, Print) Union 31. Data filed (Mont) 32. Ragistar's Signature State

in Davidson

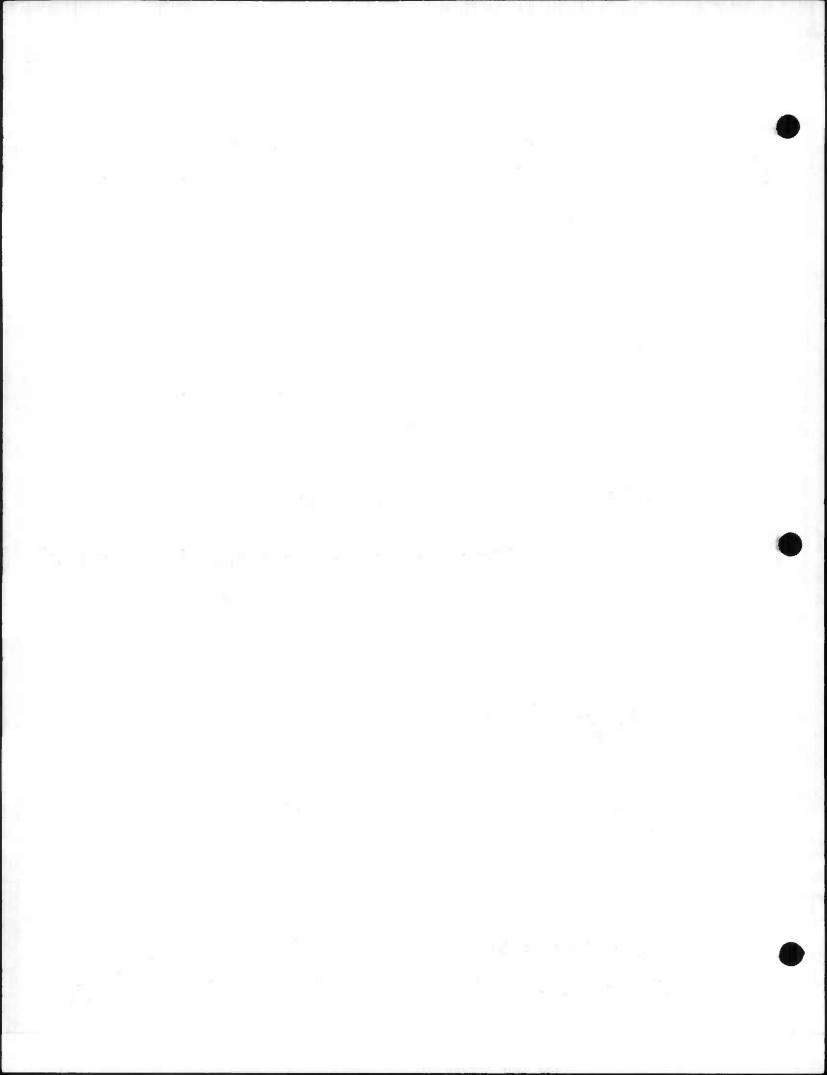
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

14753

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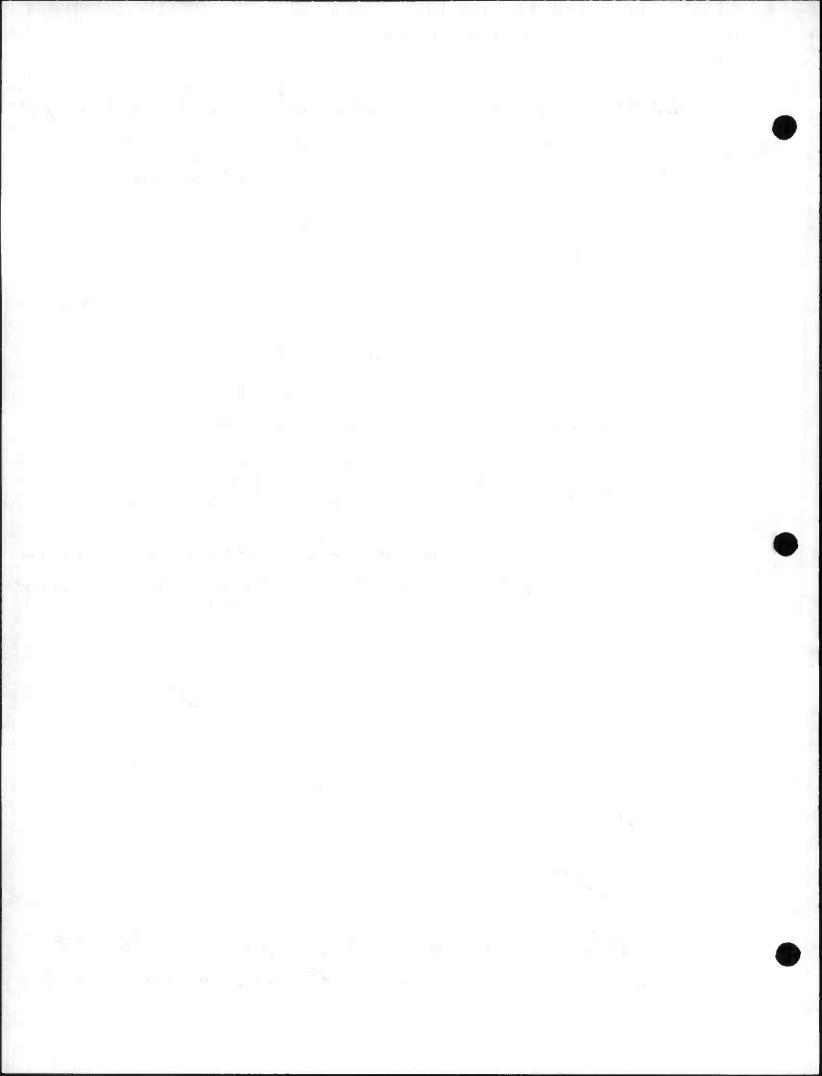


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** DELMAR Blevin LLOYC /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpiaca (Stata or Foraign Country) **Funeral** Months Days 1√2 M 2□ F Yrs 173-32-6646 Director 54 NOV 28,1942 PENNSYLVANIA Usual Rasidanca of Decedant the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits show tem 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Madical Examinating that be indiffed at Director 1 ☐ Yas 2 ➡ No MARYLAND CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2203 FRIDINGER MILL ROAD 21157 USA death Funeral 12. Was Dacedant Evar In U.S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Biack, Whita, atc. 72 hours after 1 ☐ Navar Married 2 ☐ Marriad 1 Yas 2 No If Yas, Giva Yaar or Datas 6/14/1960 Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ➡ No Specify: à 3 ☐ Widowad 4 ☐ Divorced WHITE 5/25/1963 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) Completed 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry filed within 7 Hygiene. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumests. Elamantary/Secondary (0-12) Coliaga (1-4or 5+) RECEIVING CLERK 12 K-MART 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be LLOYD D. BLEVINS SR ပ ERMA KESSLER 19a. Informant's Name/Raiationship (Type, Pnint) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) DARLENE BLEVINS, WIFE 2203 FRIDINGER MILL RD, WESTMINSTER, MD 21157 20b. Piaca of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burlai 2 Cramation 3 Ramovai from Stata 4 Donation 5 □ Othar (Specify) CARMEL CEMETERY 5/3 LITTLESTOWN, PA 21. Signatura of Funeral Service License 22. Nama and Addrass of Facility ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074 23a. Pert1. Entar tha diseasa, or complications that caused tha death. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on each line. **Physician** a Acute Myocardial Infarction
Due to (or as a consequence of):
Atheroscleratic Cardiovasculor Immediata Causa (Final disaase or condition rasulting in deeth) /Medical Examiner Examiner ear that the death certificate be executed Sequantially list conditions, if any, laading to immediate cause. Entar Undarlying Cause (Disaasa or Injury that initiated events rasulting In daeth) Last pue -leunq physician s the buriel P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of): attending for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobaccouse contributa to the cause of death? the à 1 Yes 2 No 3 Probably 4 Unknown signed t Division of Vital Records, þ 24b. Wara autopsy findings evailabla prior to completion of causa of daath? 24a. Was an autopsy Completed peen pege 2 s 1 🗆 Yas 2 1 No 1 ☐ Yas 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes casa rafarred to medical axaminar? Be 26. Placa of Daath (Check only one) Hospitai: Othar: 4 Nursing Homa 5 Residance 6 Othar (Specify) 1 Yas 2 Certification: To 1 Inpatiant 3 DOA 2 ER/Outpatient 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Wetural 5 Pending Invastigetion 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datamined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homlcide Medicai 29a. Certifian Certifying Physician: To tha best of my knowledge, death occurred at tha tima, date end place, end dua to tha causa(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signature and titla of/certifiar 29c. Licansa number 29d. Data signed (Month, Gay, Year) of person who complated causa of death (Itam 23a) (Type, Print) Westminster MD State Registrar

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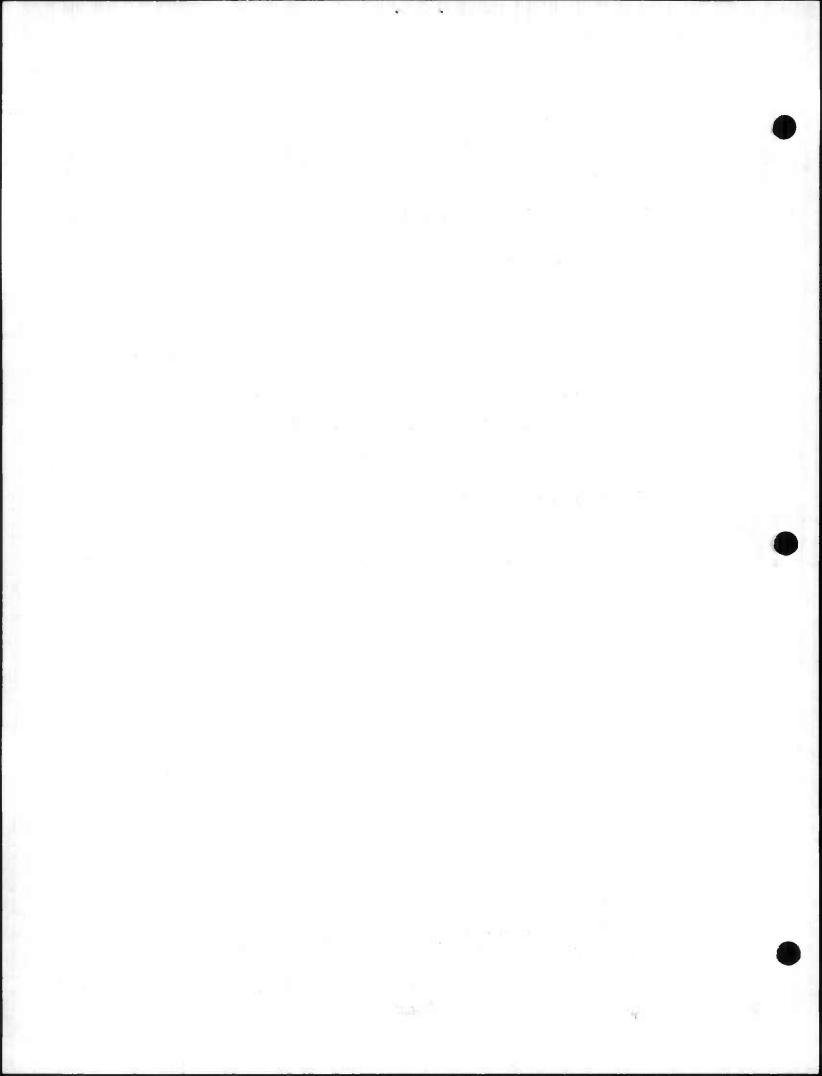
State of Maryland / Department of Health and Mental Hygiene

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ä	permit. Pages 1 and 2 should be Depertment of Haalth and Ments Important: If Item 27 is marked any injury or other traumatic enoses.		X any 1	_	-			H.S	. W	lashir	nato	on & S	ons,	Inc.		
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Division of Vital Records,	Attending Physician: Thir death. ector: After this certificate by the funeral director, par	Be	25. Was casa rafarred to medical axaminar?							26. Placa	of Deat	h (Check only	ona)			
_	Physic this ce al dire	To	1 ☐ Yas 2 ☐ No	Hospitai:	Inpatiant 2] ER/Out	patient	3 DO	A Ot	har: 4/2 Nu	rsing Ho	ma 5 Ras	Idance 6	Other (Speci	(fy)	
0	er th		27. Mannar of Death	28a. Data	of injury	28b. T		28	Bc. Inju Wo	ry at		28d. Dascribe	how injury	occurred		
ō	offing th. After offine	atio	1 XX Natural 5 ☐ Panding 2 ☐ Accident Investigation	(MON)	th, Day Year)	"	ijury	М		Yas 2∐!	No					
118	after death Director: /	fice	3 Suicida 6 Could not be	28a. Piace	of Injury - At h	noma, far	m, strea	at, factory	offica					Number or Rur	al Routa Number,	
	7 4 5 0	Certification:	4 Homicida	buildi	ing, atc. (Speci	ify)						City or To	wn, Stata)			
	apita ours veral		29a. Cartifiar (X) Certifying Phy	rsician: To the	best of my kno	owledge	daath d	occurred a	at the ti	ma data an	d place	and due to the	Callea(e) a	and manner as	stated	
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	(Check only 2 Madical Exami	iner: On tha b	asis of axamina	ation and	Vor Inva	stigation,	in my	opinion, daa	th occur	red at tha tima	data and p	place, and dua t	to the causa(s)	
	o thi o thi	Me	29b. Signature and Methot certifier					29c	. Lican:	sa number			29d. Data	signed (Month,	Day, Year)	
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			1-1-				*		1	033:	ر ر	1	L. T	_ 23,1		
			30. Nama and addrass of person who o	omplated caus	sa of death (ita	m 23a) (Type, P	rint)		Sui	te	1045				
			Lee Jonathan M	usher	M.D.	553	0 W	<i>lisco</i>	ons	in Av	ve.	Chevy	Cha	se.Md.	20815	

DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** MARGIE V. BOWERS 1997 APR. 26, 12:15 AM /Medicai 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner MONTGOMERY CO. NATIONAL LUTHERAN HOME ROCKVILLE 5. Social Security Number If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) 9. Birthplace (Stete or Foreign Country) VIRGINIA **Funeral** Deys Hours 1 □ M 2/2 F 223-42-8389 92 Director Yrs Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits VA. NONE 1 Yes 2 □ No Director RICHMOND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2411- GAYTON ROAD 23229 U.S.A. Funeral daath Home : 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, "natural", or item Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 WHITE 1 ☐ Yes 2XNo Completed by 3 ☐ Widowed 4 ☐ Divorced the Medical 18a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Eiementery/Secondary (0-12) ROCKINGHAM CO., VA. Hygiena. College (1-4or 5+) DEPUTY CLERK CIRCUIT COURT 12 .. Pagas 1 and 2 should be filed w tment of Haaith and Mental Hygier tant: if item 27 Is marked other th jury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be IRA. B. BOWERS ADA G. SHANK 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9701 - VEIRS DR., ROCKVILLE, MD. 20850 REV.DR. RICHARD REICHARD 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 X Burlal 2 □ Cremation 3 □ Removal from State permit. Paga Department of Important: If any Injury or 5/3/97 WOODBINE CEMETERY HARRISONBURG, VA. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility HYSONG CO., INC. 1300- N STREET, NW, WASH., DC that ceused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting In death) Intraventricular Hemorrhage 2 weeks **Examiner** Examiner He moor hage Intra cereval The law requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? cartificata has been signed by rector, page 2 should be detact Alzheimer a Dementia 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? ascular Diseas 1 ☐ Yes 2 ☐ No tolemocarcenema or Attending Physician: 25. Was cese referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No this 27. Menner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftar t 5 Pending Investigation 1 Netural To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completaly filled in by the fu daath. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homleide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) end manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) 29b. Signature and title of coming 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) CHRISTOPHER SCHEMM- 9701- VEIRS DRIVE, ROCKVILLE, MD. 31. Date filed (Month, Dev. Year) 32 Registrer's Signature State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

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	Physic /Med		1. Decedent's Neme (First, Middle, L Owen Franklin B		t					2. Dete of I Month Apri	Day	9 7	3. Tim f th	
	Exami		4e. Facility Neme (If not institution, gi Hillhaven Nursi					4b.	City, Town, o	phi phi			eorge's	
J.	Funeral Director		534-01-1568	Sex 1⊠M 2□F	7. Aga (In yrs. I 84	lest birthday) Yrs.	If Under 1 Y Months D		f Under 24 H Hours Mi		Birth Dey, Year) 5, 1913	9. Birtt Cor Mi	nplece (Stete or Foreig untry) nnesota	
	death with the Maryland ms 23s or 28s-f show	tor	Usuei Residence of Decedent 10e. Stete 10b. County Maryland Montgon	nery	10c. City	, Town or Lo	ocation Ashton						10d. Inside City Limit	
	th with the 23s or 28	Funeral Director	10e. Street and Number 17434 Avenleigh	Drive			10f. Zip Co	de 2086	1		10g. Citizen of	Whet Co		
020	or the	þ	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Fo	edent Evar In U. orces? 2 No va 1942- oetes: 1946	S. 13.	Was Decedant If Yes, specify 1 ☐ Yes 2 ☒		anic Origin? Mexican, Pu Specify:	(Specify Yas or I erto Rican, atc.)	No- 14. Rad Ble Specif	ck, White	ncan Indian, i, atc. Thite	
Maryland 21215-0020	within 72 ene. than *nat	Be Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation		(Give	DO NOT use re	done durina most of working				al R	esearch atory	
yland 2	be file ital Hyy d othe evant,	To Be Co	17. Fether's Neme (First, Middle, Las Franklin August		dt				3. Mother's N		lle, Maiden Surner		acory	
Mar	2 st enc is m	ľ	19e. Informent's Neme/Reletionship Robert O. Borcha		on			treet end Number or Rurel Route						
Baltimore,	permit. Pages 1 and 2 should Department of Health end Mer Important: If Item 27 Is marke any Injury or other treumatic ance.		20e. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 [☐Removei from	State 20b. P	17434 Avenleigh Drive, Ashton, Marylan Placa of Disposition (Neme of cometery, cremetory or other piece) Dete 20c. Location - Cit Sarnabas Cemetery 5/2/97 Upper Ma						- City or 7	Town, Stete	
Baltin	permit. Pages Department of P Important: If Ne any Injury or of once.		4 Donetion 5 Other (Special Signature of Funeral Service Lice	nsee	Sasc	() F1	Name end A	ddress of Gas of	of Facility	5/2/97 ons Fune	eral Home	. P.	A. 20781	
			23a. Pert1. Enter the disease, or comshock, or heart feilure. List only	plicetions thet of one ceuse on a	caused the death								Approximata Intervel Between	
	Physician /Medical Examiner	ŀ	Immediate Ceuse (Final disaasa or condition resulting in death)	A .	PIRATI	010	NERW	NO.	IA			-	Onsat and Death 48 HOUR	
			,	PA	Due to (or	es e consec	quence of):	E					48 HOUR 5 YEARS	
,0	e executed lan and unal-transi	Exami	Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Disease or Injury	b		es e consec	1					1		
ox 68760,	certificete be executed nding physician and use as the burial-transit	n/Medicai Examiner	that initiated events resulting in death) Lest	d	Due to (or es e consequenca of):									
ω.		Physiciar	Pert II. Other algnificant conditions	contributing to de	eeth but not resu	lting in the u	nderlying cause	e given l	In Pert I.	23b. DI	d tobacco use co	entribute	to the cause of deat	
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Vital Records,	2 S S	Completed								24a. Wa	as an eutopsy formed?	8	Vere autopsy findings vallable prior to completion of cause of death?	
al B	F age									1	Yes 2 No	1	☐ Yes 2█ No	
Ę	Physician: this certific ral director,	To Be	25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2 🗆 I	ER/Outpatier	at 3 DOA	Other:		eeth (Check only	vone) sidence 6 □Oth	(C		
sion of	After fune		27. Manner of Deeth 1 Neturel 5 Pending investigetio	28e. Dete (Moni		28b. Time of Injury	28c.	Injury et Work? 1 Yes		1	e how Injury occur		ny)	
Division	tal or Attendirs after deatl al Director: led in by the	Certification:	3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify)								(Street end Numb own, Stete)	ber or Ru	ral Route Number,	
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in I	edicai	29a. Certifier (Check only one) 1 ☑ Certifying Ph 2 ☐ Medical Exam	minar: On the be	best of my know esis of examineti ner steted.	vledge, death on end/or inv	occurred et the	ne time, ny opini	date end plea on, deeth occ	ce, end due to th curred at tha time	e ceuse(s) end ma a, date and piece,	anner as end due	steted. to the cause(s)	
	To th To th comp	Me	29b. Signatura multitle of coltables 29d. Dete signed (Month, Day, D3) 563 May 1, 1997											
	(5)	30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)												

Dr. Charles M. Benner, 11251 Lockwood Drive, Silver Spring, Maryland 20901

DHMH 16 Rav 6/95

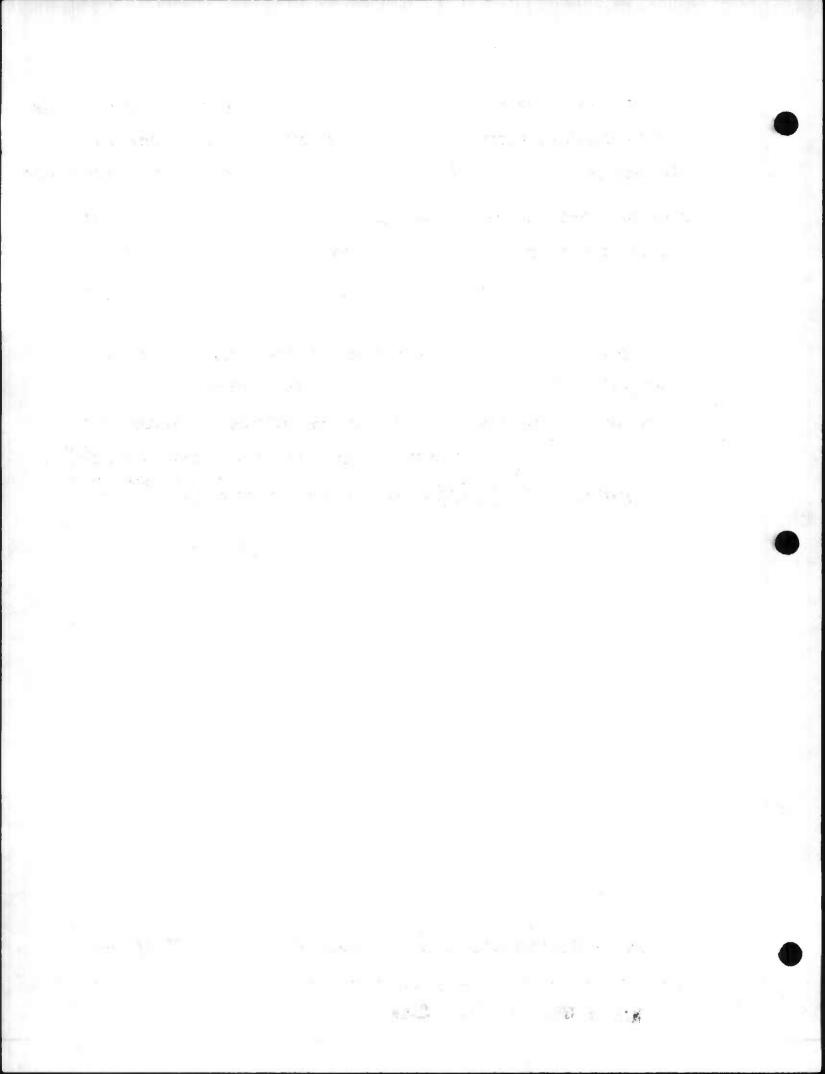
State Registrar 31. Dete filed (Month, Dey, Year)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death **Physician** TIMOTHY BROWN APRIL 28, 1997 4:28AM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) **Funerai** Birthplece (State or Foreign Country) **X**IXM 2□ F Months Days Hours 54 Yrs. 248-68-3343 Director JULY 16,1942 LAKE CITY,SC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director MARYLAND PRINCE GEORGE'S XX Yes 2 No CHEVERLY the 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 6 3126 LAUREL AVENUE 23a 20785 USA Rems : 11. Maritel Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. filed within 72 hours after thygiene. 1 Never Married Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondery (0-12) College (1-4or 5+) 12th DC GOVERNMENT CORRECTIONAL OFFICER (RET.) 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Surneme) . Peges 1 and 2 should be file ment of Health end Mental H-lant: If item 27 is marked oth jury or other traumatic even ELMOND BROWN, SR. BEULAH CAMERON 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLYN L. BROWN/ WIFE 3126 LAUREL AVE. CHEVERLY , MARYLAND 20785 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete SOUTH 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3X Removei from State permit. Pege Depertment of important: If any injury or once. SANDHILL MEMORIAL PARK 5-3-97 LAKE CITY , CAROLINA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility MARSHALL'S FUNERAL HOME OF MD 21. Signeture of Funeral Servica Licansee 4308 SUITLAND RD. SUITLAND, MD Park Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediate Cause (Final Cardiopulmonary mmutes disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner scheroderma physician and the burief-trensit The law requires thet the death certificete be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): interstitual Box 68760. disease Physician/Medical Due to (or es e consequence)f) 80 P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown been signed I should be det Records. by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 1 Yes 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To this 27. Menner of Death 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Avaturei death. 1 Yes 2 No 24 hours efter deaf Funeral Director: 8 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 123 Certifying Phyeician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the ceuse(s) and manner as stated.
2 Madical Exeminer: On the bests of examination end/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) end manner stated. Medical 29e. Certifier (Check only one) within 2 To the the th 29b. Signature end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 0 28 97 a . « 050367 uia, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GARCIA SILVER SPRING MP 20912 MOCY CROSS FOSPITAL 31. Dete filed (Month, Dey, Year) 32, Registrer's Signeture State Mille Moulean Revall Registrar

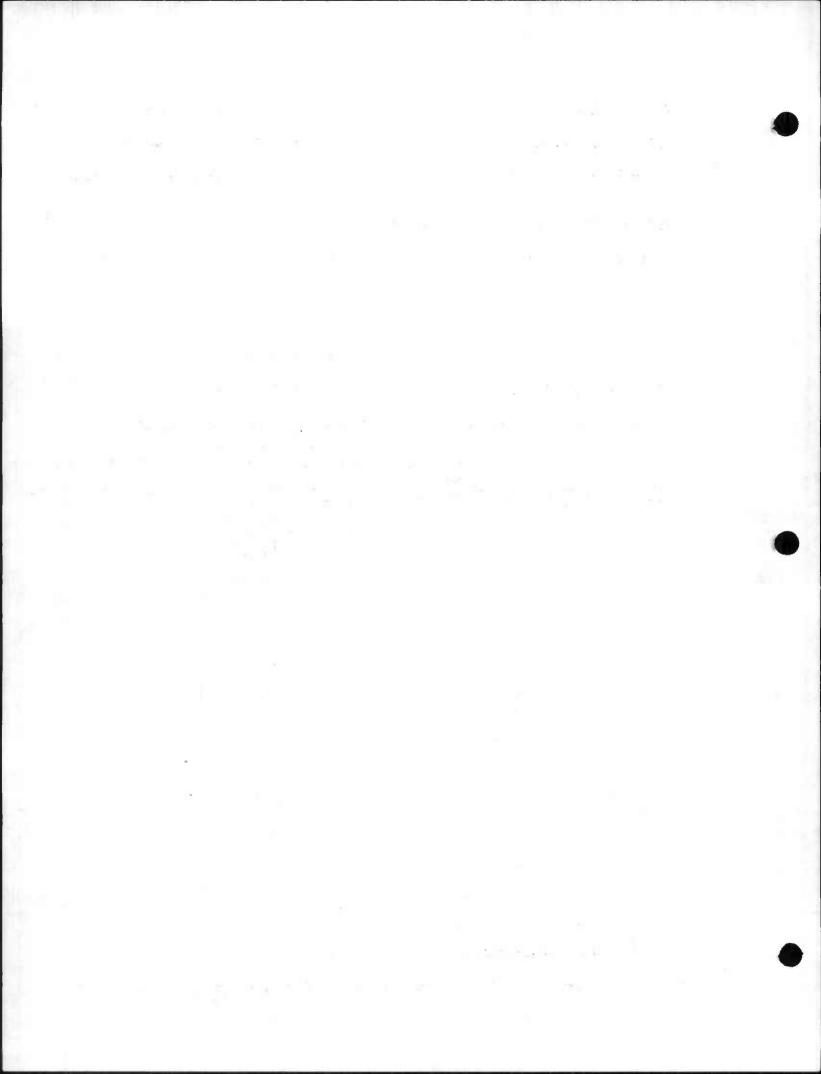
DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

-					,				Death	ivieritai riy	Reg. No.	97	14759
	Physic		1. Decedant's Name (First, Middla, La							2. Data of De Month	Day	Year	3. Time of Death
	/Medi Examii		Virginia Lawson 4a. Facility Name (# not institution, given	a street and number)					4b. City, Town, or	Location of Death	27, 199 4c. County	•	10:30 AM
	Funeral Director				e (In yrs.	last birthday) Yrs.	If Unde Months	r 1 Yaar Days	Takoma If Undar 24 Hrs. Hours Min.	8. Date of Bird (Month, Da			ry ace (Stata or Foreign ry) rgia
	show	7	10a. State 10b. County		10c. Cit	ty, Town or Loc	cation					10	d. Inside City Limits
	ith the Maryland or 28a-f show	Director	Maryland Montgo	omery		Takoma		k Code			10g. Citizen of	What Count	1 ☐ Yes 2 X No
020	72 hours effer death with the Maryland insturet, or items 23a or 28e-f show olds! Evant ver must be notified at	by Funeral	7812 Carroll A 11. Marital Status 1 □ Nevar Married 2 □ Married 3 □ Widowed 4 仅 Divorced	12. Was Decedant Armed Forces? 1 □ Yes 2 [X] If Yes, Give Year or Dates:					12 dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	- 14. Rac	d Sta ce - Americe ck, White, e	n Indian, tc.
2121	yiene.	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ade completed) Collega (1-4or 5	i+)		kind of wo OO NOT u	ork done sa retire	during most of word) choanaly	st		usinass/ind	
Maryland	o d it o	To Be	17. Father's Name (First, Middle, Last, Phineas Lawson (Clower					18. Mother's Nar				
more,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any injury or other treumetic ance.		19a. Informant's Name/Relationship (Ann Candace Garne 20a. Method of Disposition 1 □ Burlal 2 🖾 Cremation 3 □ 4 □ Donation 5 □ Other (Specifications) 21. Signature of Funeral Sarvice Licer	Str me of other pla emat and Addra	reet, Irving, Texas 75063 reet, Irving, Texas 75063 place, April 30, 1997 atorium, Inc. drass of Facility Pumphrey Funeral Home/Bethesda-Chevy Chasensin Avenue, Bethesda, Maryland 20814-350								
08700,	Chysician Physician and Medical Example of the private ransit of t	Medical Examiner	immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b	Due to (o	al Cell or as a consequ or as a consequ or as a consequ	uance of)		Metasta	tic			2 years
s, r.C. box	The law requires that the death certate hes been signed by the attendinges 2 should be detached for use	by Physician/M							an in Part i.		Did tobacco use contribute to the o		
necords	sicien: The law requires certificate has been sig lirector, page 2 should b	Completed b							-	perfo	an autopsy med?	com of de	a autopsy findings lable prior to plation of cause eath?
אוומ	hysician: this certifica al director,	To Be	25. Was casa raferred to medicat axaminer? 1 ☐ Yes 2 ☒ No			ER/Outpatient			ar: 4□ Nursing H	ome 5 🖾 Resid		er (Specify)	
DIVISION OF VITAL RECORD	or ing	Certification:	27. Mannar of Death 1 Natural 2 Accident 3 Suicide 4 Homicida 5 Pending investigation 6 Could not be determined		ıry - At he	28b. Time of injury	М		y at k? Yes 2 □ No	28f. Location (S City or Tow	Street and Numb		Route Number,
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f	edicai Ce	29a. Certifier 1\(\bigotimes\) Certifying Ph (Check only one) 2 \(\bigotimes\) Medical Exam	ysician: To the best of the basis of and manner sta	examinal	wiedge, death o	occurred astigation	at the tir	ne, data and place pinion, daath occu	, and due to the c rred at the time, c	cause(s) and ma date and place,	inner as sta and due to t	ted. ha cause(s)
	Multhin 7 To the complete	Z	29b. Signatura and fittle of certifiar One of the second	D40216			29d. Date signed (Month, Day, Year) April 28, 1997						
	Sta		Dennis A. Cullen, 31. Date filed (Month, Day, Year)	M.D. 545	54 Wi		n Av	enue	, #1625,	Chevy C	hase, M	D 20	815

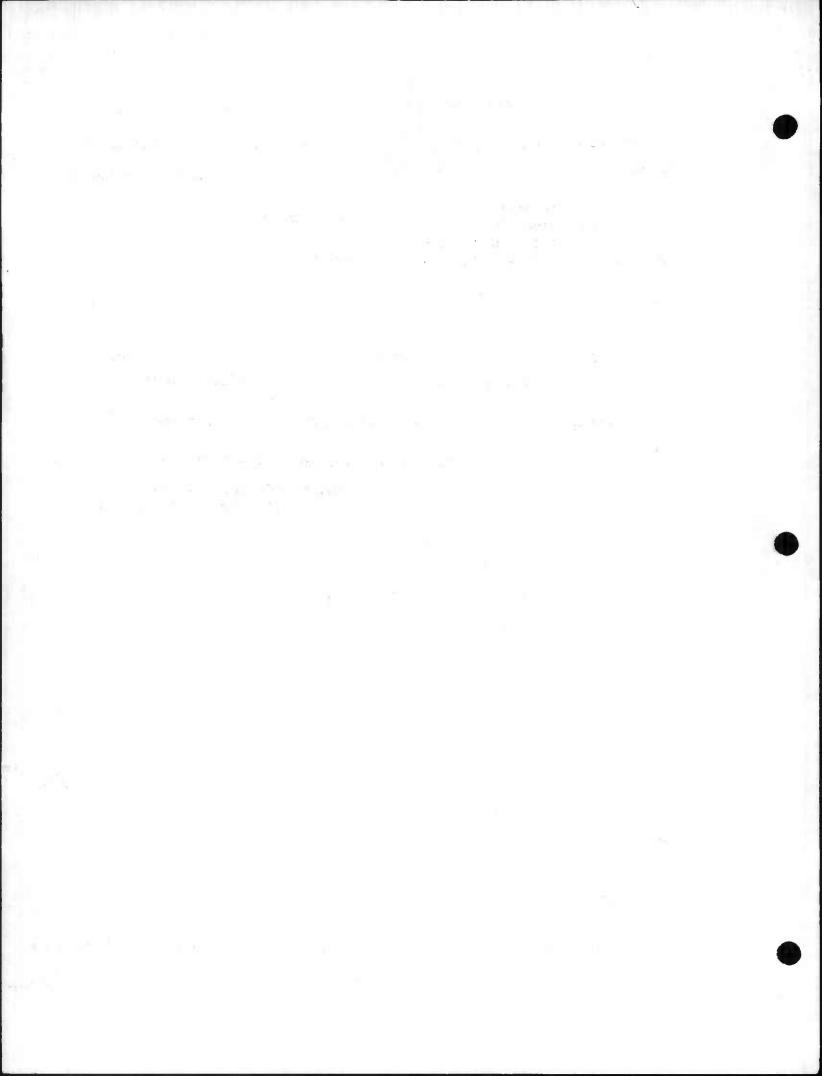
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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	sicia: edica	n	1. Decedent's Nem	ne (First, Middle, La		SE COM	1ENS					2. Deta of E Month O4		Yaar 97	3. Time of Deel	
	mine	_	4a. Fecility Neme ('If not institution, giv	e streat end num	iber)			4	b. City, To	wn, or L	ocation of Da		h 4c. County of Deelh		
				GROVE AD	VENTIST	HOSPI'				Rockville			Montgomery			
Fune Direct			5. Social Security N 182–18–1	L552	Sex 1 □ M 2]X] F		last birthday,		Year Deys	If Under Hours	24 Hrs. Min.	8. Dele of E (Month, I	lirth Dey, Year) 18–06		plece (State or Formatry) dock, PA	
pug *		-	Usuel Residence o 10e. Steta	10b. County		10c C	ity, Town or L	ocalion							10d incide Oh. Lie	
ours efter deeth with the Merylan sl', or items 23a or 28s-f ahow		Director	MD	Gaithe	rsburg mery Cnt		Gaithersburg								10d. inside City Lin 1⊈ Yas 2 ☐	
5 th		SILE.	10e. Street end Nu		se Villa	-	ıse	10f. Zip Co	ode				10g. Citizen	log. Citizen of Whet Country?		
23a		a	Club Hou	use Rd. &	Montgon	nery Av	7e.	20	87	7				USA		
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permit. Peges 1 en Department of Heel Important: If Item 2 env injury or other	DUC.		21. Signalure of F	nerel Service Lige	nsee		22. Nama and Addrass of Facility									
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s efte	Cortification	5	4 Homicide		buildin	g, etc. (Speci	fy)					City or T	own, Stete)			
To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	odical	3	29e. Certifier (Check only one)	Certifying Ph 2 Medical Exam	yelclen: To the b niner: On the bas end menne	sis of examine	owledge, deet etion end/or in	h occurred et t vestigation, in	he tim my op	e, dete en inion, deel	d plece, th occur	end due to th	e ceuse(s) end e, dete end plea	manner es s ce, and due t	iteted. o the ceuse(s)	
ro th romp	N		29b. Signeture end	title of cartifier	-			29c. L	cansa	number			29d. Data sig	nad (Month,	Day, Year)	
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	istrar			APK 2	9 1997	gran	a vavidse	n-yande								
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State of Maryland / Department of Health and Mental Hygiene

14761 Certificate of Death 1. Decedent'a Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year Carrie Smith Crockett April 26 1997 /Medical 9:30 AM 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 749 Thayer Avenue Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthpiace (Stete or Foreign Country) 1 ☐ M 2 🕱 F Director Yrs. 217-32-9314 Jan. 16,1900 Maryland Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Exactiner insuit be notified at Director 1 ☐ Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò or items 23a 749 Thayer Avenue Funeral 20910 death U.S.A. 12. Was Decedant Ever in U,S. Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or the may injury or other traumatic event, the Medical Exaction 2008. 1 Never Merried 2 Married & Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2₺ No Specify: by 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highast grede completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) Coilege (1-4or 5+) Secretary Plumbing/Heating 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Sumeme) William Smith Betty Wayson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) J. Roy Lee 4068 Cadle Creek Road Edgewater, Maryland 21037 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Mathod of Disposition 20c, Location - City or Town, State Date 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/29/97 Brentwood, Maryland Fort Lincoln Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Sil. Spr., Maryland 20901 23e. Part! Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervei Betw **Physician** /Medicai Immediate Ceuse (Final Cardio-respirators disease or condition resulting in deeth) **Examiner** Physician/Medical Examiner Cardiac Arrhythmic siclan and burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to Immediate cause. Enter Undarlying Cause (Disease or Injury that Initiated events resulting in death) Last Obstructive Pulmonon Disease P.O. Box 68760, physiclan s the buria Dua to (or as a consequence of): 93 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 15€Yes 2 No 3 Probably 4 Unknown signed t Records, þ page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2, No 1 ☐ Yes 2 ☐ No of Vital or Attending Physicien: Be 25. Was case referred to medical 26. Piace of Death (Check only one) Other: 4 Nursing Homa 5 Aesidenca 6 Other (Specify) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this funeral 27. Menner of Death Dete of Injury (Month, Dey Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how Injury occurred After Division Neturel 5 Pending investigation To the Hospital or Attending within 24 hours efter death.

To the Funeral Director: Aft completely filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 26f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) end manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 10 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Phillip W. Poth, M.D. 831 University Boulevard, West Silver Spring, Maryland 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State Registrar

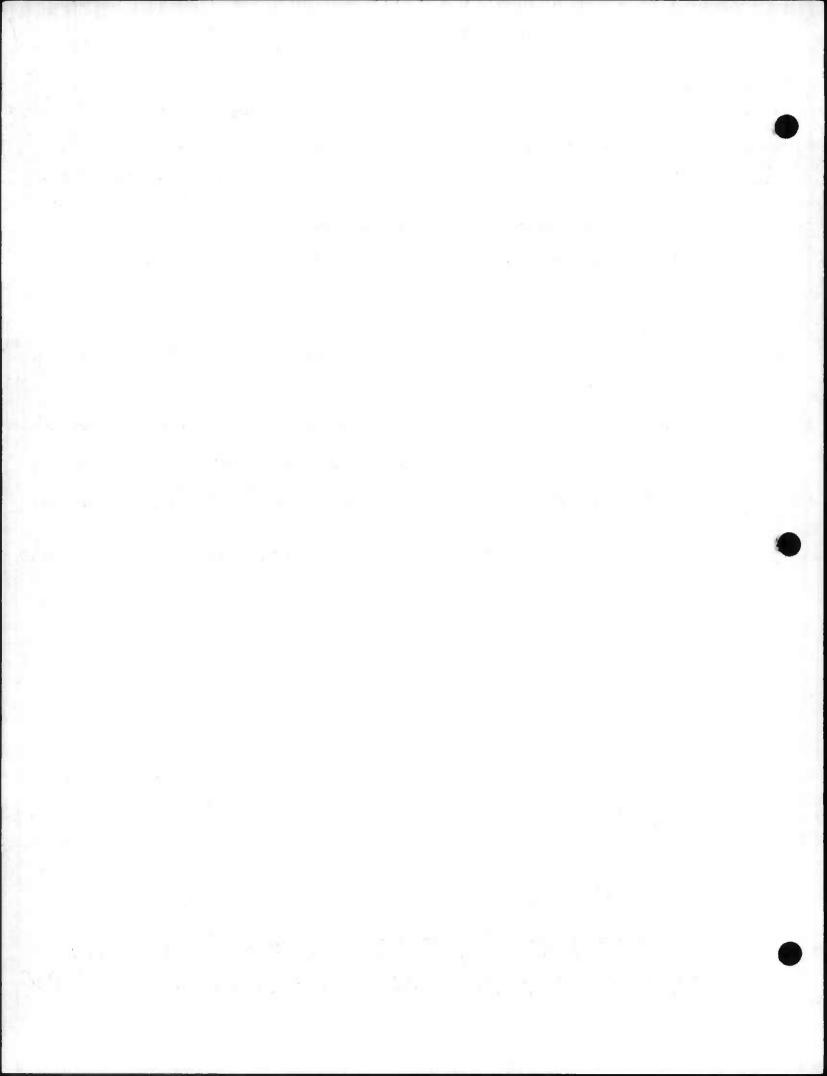
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

			e of Death	R	eg. No.	14762						
Phys	sician	1. Decedant's Nama (First, Middla, Last)		2. Data of Deat Month	h Day Yaar	3. Tima of Death						
	dical	Eileen Kane Campbell		April 28		1:25 PM						
Exar	miner			Location of Death	4c. County of Dea	ath						
		9106 St. Andrews Place 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If Unda	College 1 Yaar If Undar 24 Hrs		Prince G							
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h the	Director	Maryland Prince George's College 10e. Street and Number 10f. Zi	Coda	10	0g. Citizen of What C	ountry?						
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			(Street and Number or F			Zip Coda)						
1 end 2 Health em 27 li				e Colleg	e Park, Ma	ryland 20740						
Pages 1 e nent of Hein int: if Item iry or othe		20a. Mathod of Disposition 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 20b. Place of Disposition (Naccematary, cramatory or complete the complete that the complete tha	na of thar place)	Data	20c. Location - City o	r Town, Stata						
allumore, mit. Pages 1 er pertment of Hea portent: if Nem; y Injury or other		4 □ Donation 5 □ Othar (Specify) Gate of Heaven	Cemetery	5/01/97 S	ilver Spri	ng,Maryland						
permit. Pages Deportment of Important: If it any Injury or or	OUCE		d Addrass of Facility	France 1	Home Too							
- 0026	ч	500 IIn:	J. Collins versity Blv	dW Sil	Spr. Mar							
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Physicia /Medic		Immediata Causa (Final	~			Onsat and Death						
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outed ansit	edicai Examiner	Sequantially list conditions. Dua to (or as a consequence of):				I I						
an each	Ä	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or Injury C.										
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necolus, he law requires the been signed as should be contact.	Ş Q			24a. Was ar	autopsy 24b.	Wara autopsy findings						
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10		(Caroli M Namester M)	03240	7 1	Per 29	1997						
1		30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)			NC -1							
		JOSEPH HAGGERLY 9767 MEDICAL	CENTER D	R ROCK	VILLE M	1997 D 20850						
5	State	31. Data filed (Month, Day, Year) 32. Registrar's Signatura										

Hegistra



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14763 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month Yaer Ann T. Corcoran 30, 1997 April 3:02 AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8533 Beaufort Drive Fulton Howard If Under 1 Year 5. Sociel Security Number if Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Birthplaca (State or Foreign Country) Days Hours 1 □ M 2 🔀 F Director Yrs. 054-20-3491 68 Dec.26,1928 New York Usual Rasidance of Dacedent 10a. Stete 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. inside City Limits Director 1 ☐ Yas 2X No Maryland Howard Fulton 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 8533 Beaufort Drive 20759 U.S.A. deeth Funeral 12. Wes Decedant Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Give 11. Maritei Status Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Rican, etc.) Race - American Indian, Black, Whita, atc. filed within 72 hours efter 1 ☐ Navar Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: by Specify: 3 Widowed 4 Divorcad White Completed 15. Dacadant's Education Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry (Specify only highest grada completed) I Hygiene. Elamantary/Secondary (0-12) Collega (1-4or 5+) L. Pages 1 and 2 should be filled wittened of Health and Mental Hygien tarm: If Nem 27 Is marked other that hary or other traumatic event, that 12 Homemaker Own Home 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Sumama) Be Patrick Harrigan Boyle Annie 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Ralationship (Type, Print) Charles J. Corcoran 8533 Beaufort Drive Fulton, Maryland 20759 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 5/2/97 Silver Spring, Maryland 21. Signatuse of Funeral Service Licenses 22. Nama end Addrass of Facility Francis J. Collins Funeral Home, Inc. 23e. Part. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiretory arrast,

Approximeta

Approximeta Approximeta Intervel Batween Onsat and Death **Physician** /Medical Immediata Causa (Final a Terminal Advanced B Cell Non-Hodgkin Lymphoma disaase or condition rasulting in daath) Examiner Dua to (or as a consequanca of): Attending Physician: The lew requires that the death cartificate be executed the buriel-tran Sequentially llst conditions, if eny, laading to immadiate cause. Entar Underlying Ceuse (Disease or Injury that initiated avants rasulting in daath) Lest pug Dua to (or as a consaguance of): Physician/Medical Dua to (or as a consequance of): for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by the 23b. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown signed t Congestive Cardiac Failure ð director, page 2 should Completed 24e. Was an autopsy performad? 24b. Wara autopsy findings available prior to Stp. Mitral Value Replacement completion of causa of deeth? this certificate 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarrad to medical 26. Placa of Death (Check only ona) Hospitel: 1 Inpatient 2 EP/Outpatient 3 DOA Othar: 4 Nursing Homa 5 A Residence 8 Othar (Specify) 2 1 ☐ Yas 2 XNo al or Attending Physics efter death.

I Director: After this ed in by the funeral d 27. Manner of Daath 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? 5 Panding Invastigation 1 Natural 1 Yes 2 No 2 Accidant 3 Sulcida 6 Could not be datarminad 28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 HomicIda Hospital To the Hospital
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completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the ceuse(s) end mannar as stated. Medical 29a, Certifiar 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, data and place, end due to the cause(s) and mannar steted. 29b. Signatura and titla of certifiar 29c. Licansa numbar 29d. Dete signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Data filed (Month, Day, Year) 32. Registrar's Signatura MAY 02 1997 Julia Savidson Rendere

30. Nama and address of person who complated cause of deeth (Item 23e) (Type, Print)

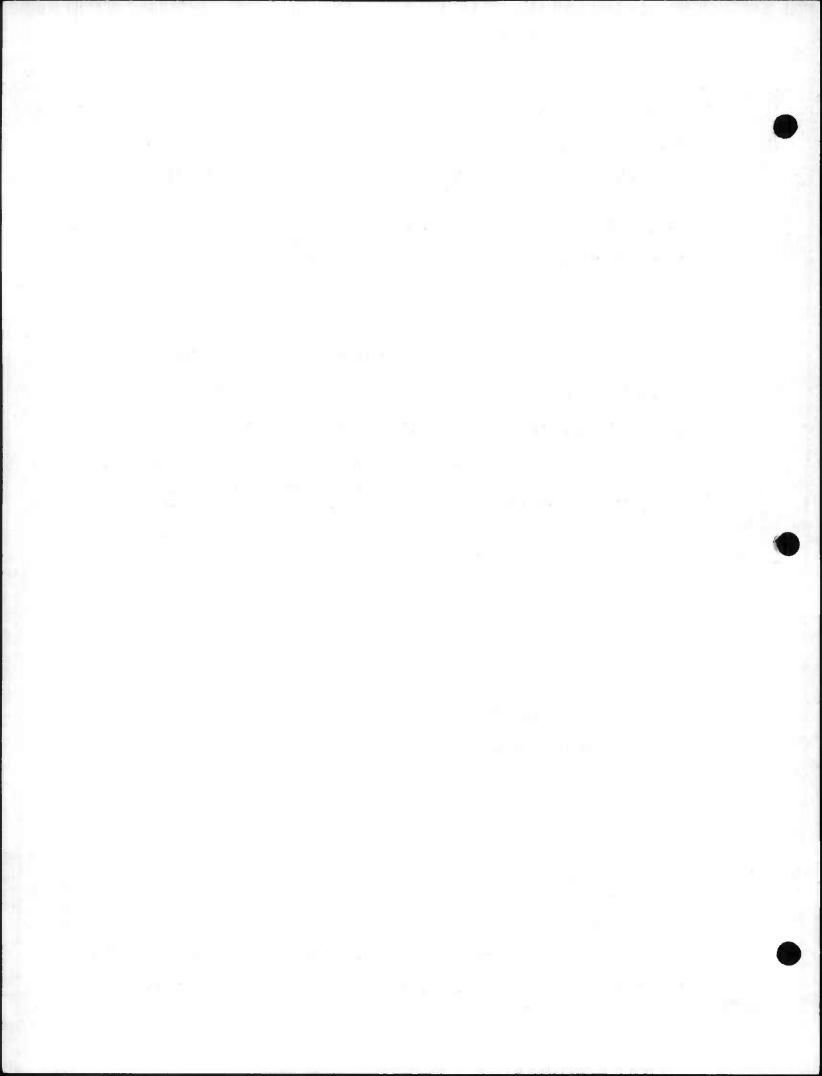
Vera Malkovska, M.D.

D 21030

110 Irving Street, NW Washington, DC 20010

April 30, 1997

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death 4a. Facility Nama (If not institution, give street and number) COFIELD 1997 APRIL 23 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 7. Aga (In yrs. last birthday) 1. Aga (In yrs. last birthday) 5. Social Sacurity Number 6. Sex 9. Birthpiaca (State or Foraign Country) North Carolina 1□ M 2 F 579-78-7095 Usual Rasidance of Decadent 10b. County 10c. City, Town or Location 10d. Insida City Limits Yes 2 No Washington 10e. Streat and Number 10f. Zip Coda 10g. Citizan of What Country? 1167 First Street, N. W. 20001 United States 12. Was Dacedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarlo Ricen, etc.) 14. Race - American Indian 1 Nevar Married 2 Marriad Specify: Black 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 8th Nursing Aid Private Industry 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) Raymond McNeill, Sr. W. Grace Cofield 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) W. Grace Cofield (Mother) 570 Nicholson St., NE, Washington, DC, 20011 20a. Mathod of Disposition 20b. Place of Disposition (Nema of cemetery, cramatory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramovel from State Metropolitan Crematory 4/29/97 4 ☐ Donation 5 ☐ Othar (Specify) Alexandria, VA 21. Signatura of Funaral Service Licensee 22. Name and Address of Facility Co. Morticians, Inc. R. M. Horton 600 Kennedy Street, N. W., DC, 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Pue to (or as a consequence of): Immediate Ceuse (Final diseasa or condition resulting In deeth) FC OUR ED DOMONO DE FICIÉNCY Sequentielly list conditions, if any, laading to immediata cause. Entar Undarlying Couse (Diseasa or injury that initiated events resulting in death) Last Due to (or as a consequenca of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ECCA C 1412 CASTRUSTONY SIGE 24b. Ware eutopsy findings available prior to completion of cause of death? 24a. Was en eutopsy 1 Yas 2 DONO 1 ☐ Yas 2 ☐ No 25. Wes cese referred to medical 26. Piaca of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

DC

Director

Funeral

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Completed

Be

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Haalth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, fra Medical Examinar must be not fed at once.

Baltimore, Maryland 21215-0020

ed by the attending physician end detached for use as the burial-tran signed by Completed certificate After this within 24 hours efter deat To the Funeral Director:

Physician/Medical

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edical Certification:

or Attending Physician: The law requires that the death certificate be executed

death.

the Hospital

filled in by

Division of Vital Records, P.O. Box 68760.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

axaminar Hospital: 1 Ampatiant 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 27. Mennar of Death 28b. Tima of 28d. Dascribe how injury occurred

28c. Injury at Work? 5 Panding invastigation 1 Naturai 1 Yas 2 No 2 Accidant

6 Could not be datarmined 3 Suicida 28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta) 4 Homicide

1 Certifying Physician: To the best of my knowledga, daath occurred at tha time, dete and piace, and due to the causa(s) and mannar as stated.

| Medical Examiner: On the best of axamination and/or investigation, in my opinion, daath occurred at tha time, data and placa, and dua to the cause(s) and mannar stated. 29a. Certifian

29b. Signature end titla of certifiar

29c. License number 29d. Date signed (Month, Day, Year)

30, Nama and addrass of person who completed ceusa of deeth (Item 23a) (Type, Print) RROLL AYE #230
K. SV DHAKAR, MD. 7610 CARROLL TAKOMA DARK. 31. Data filed (Month, Dey, Year)

State Registrar

32. Register's Sign fore

TOTAL TOTAL TRAINING

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. Amended #9, 5/5/97, JW, Mont.co. State of Maryland / Department of Health and Mental Hygiene Andread # 20b, 22, 26, 5/2/97, JW, Mont. Co. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Dey1997 Year APRIL 26, 5:45AM BEN CHARTOFF /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner sether do 6. Sex 1 → M 2 → F if Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Numbar (In yrs. last birthday) If Undar 1 Yaar **Funeral** Months Deys Hours 462-20-2592 Director 95 New York Usual Rasidence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28s-f show traumetic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MARYLAND | MONTGOMERY POTOMAC 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 Itema 23a 10115 BENTCROSS DRIVE 20854 USA deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Rece - Amarican Indien, Bleck, White, etc. pernit. Peges 1 and 2 should be filed within 72 hours after Copertment of Health end Mental Hygiene. Important: if item 27 is marked other than "naturel", or itel any injury or other traumatic event, the Medical Enginest any injury or other traumatic event, the Medical Enginest Spice. 1 Never Married 2 Married 1 Yes 2 No If Yas, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify: 3 Widowad 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highest grada completed) Elementary/Secondery (0-12) College (1-4or 5+) OWNER PIPE AND STEEL DISTRIB 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maldan Surnama) ABRAHAM CHARTOFF SONIA GUBERMAN 19e. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) JOE CHARTOFF/SON 10115 BENTCROSS DRIVE, POTOMAC, MD 20b. Plece of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete /27/97 1 Duriel 2 Crametion 3 Removet from State KING DAVID MEMORIAL GDNS 2/27/95 FALLS CHURCH, VA
Danzansky
SANZNASKY GOLDBERG MEMORIAL CHAPELS, INC. 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Sarvice Licansee 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner ua to (or es e consequence of): Examiner -transit The law requires that the death certificate be executed Saquantially list conditions, if any, leading to Immediate causa. Entar Undarlying Cause (Diseese or Injury that Initiated events rasulting in deeth) Last and Due to (or es e consequence of) ettending physician a for use es the burial-P.O. Box 68760. Physician/Medical Due to (or as a consequenca of) significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown þ Records, Completed 24b. Were autopsy findings available prior to completion of cause of daath? page 2 should 24a. Was en eutopsy performed? hes 1 ☐ Yas 2 TNo 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifice completely filled in by the funeral director, p Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: Othar: 412 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Daeth 28e. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury et Work? Neturel 5 Pending 1 ☐ Yas 2 ☐ No 2 Accidant Investigation 3 Suicida 6 Could not be 28e. Plece of Injury - At home, farm, straat, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide Certifying Physician: To the bast of my knowladga, daath occurred at tha tima, data end plece, end due to the cause(s) end mennar es statad.

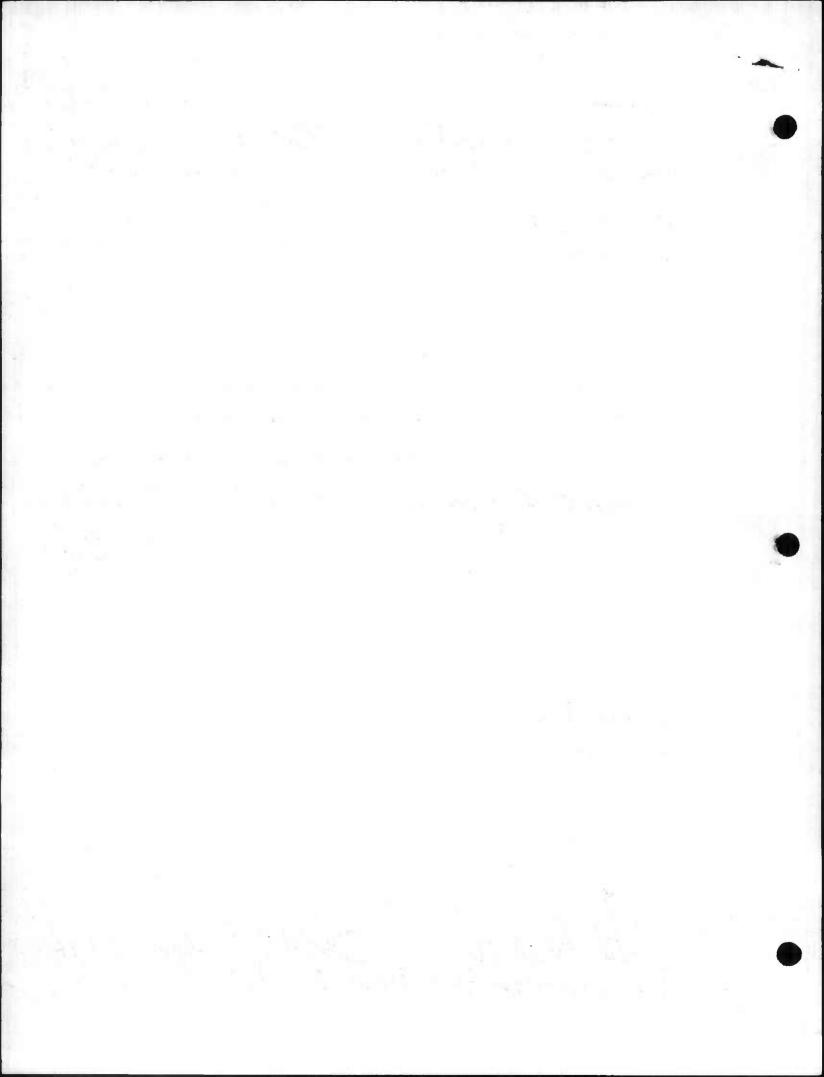
| Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and mannar statad. Medical 29a. Certifiai (Check only one) 29b. Signeture 29d. Dete signed (Month, Day, Year) 30. Name engreddress of person who completed cause of deeth (Item 23a) (Type, Print)

LTV + CWN W 5408 KOO

State Registrar 31. Date filed (Month, Day, Year)

32. Ragistrar's Signeture

alla.



State of Maryland / Department of Health and Mental Hygiene 4766 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Alma F. Carev April 24 1997 6:43 PM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Doctor's Community Hospital Prince George's Lanham 8. Date of Birth
(Month, Day, Year)
Jan. 21,1909

9. Birthpiace Country)
North Carolina If Under 1 Yeer If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 M 2 P F Months Deys Hours Min 88 Yrs. 10c, City, Town or Location 10d. inside City Limits

Funeral Director

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

r than "natural", or itema 23a or 28a-f show the Mexical Examiner must be notified at

Frances Carey

7 is marked other than traumatic event, the Ma Peges 1 and 2 should be filed with nent of Health end Mental Hygiene. Important: If item 27 is any injury or other traus Department

Physician /Medical **Examiner**

The law requires that the death cartificate be executed the bunal-transit P.O. Box 68760, 98 signed by the a Records, page 2 should Division of Vital Hospital or Attending Physician: director. Be Certification: To After this in by the funeral 24 hours after death. Funeral Director: A Medical To the within 2 To the

Physician/Medical Examiner Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. þ Completed

5. Social Security Number 577-42-8801 Usuel Residence of Decedent 10e Stete 10b County Maryland Prince George's University Park 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6703 44th Avenue 20782 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) John David Powell Melissa Ann Davis 19a. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Phillip W. Harris - Son 6703 44th Avenue, University Park, Maryland 20782 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Fort Lincoln Cemetery 4/28/97 4 □ Donation 5 □ Other (Specify) Brentwood, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Feclity Francis Gasch's Sons Funeral Home, P.A. 110 4739 Baltimore Avenue, Hyattsville, MD 20781 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Immediete Ceuse (Finat diseese or condition resulting in deeth) PNEUMONIA ASPIRATION Due to (or es e consequence of): Alzheiner 1 DIJEAJE

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in death) Lest

Due to (or es e consequenca of): Due to (or es e consequence of):

1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1/ Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner steted. 29e. Certifier



State Registrar Benans

7305 BALTIMORE AVE (07 College Parce MS)

29c. License number

026287

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) MichAEl

Urcharl Burand, and

29d. Date signed (Month, Dey, Year)

23b. Did tobecco use contribute to the cause of death?

1⊠ Yes 2□ No

White

Approximete Interval Between Onset end Deeth

i day

31. Dete fited (Month, Day, Year) APR 28 1997

29b. Signeture end title of certifier

32 Registrar's Signature

A street

State of Maryland / Department of Health and Mental Hygiene 14767 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death **Physician** Cole Edith /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deal Examiner Cecil Union Hospital of Cecil County E1kton If Under 1 Year 8. Dete of Birth (Month, Day, Year) 9. Birthplece (State or Foreig March 23, 1918 West Virginia 5. Sociel Security Number if Undar 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign **Funeral** Days 1 □ M 2 X F Director 79 Yrs 220-20-0929 Usuel Rasidenca of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits -7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinal must be notified at Maryland Cecil Elkton Director 1 X Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21921 U.S.A. 204 Locust Lane Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or fren any Injury or other traumatic event Bleck. White, etc. 1 ☐ Yas 2 🕱 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No þ Specify: 3 X Widowed 4 ☐ Divorcad White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) College (1-4or 5+) Clothing Construction Seamstress 8 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Birdie May McCutcheon Winfield Scott Hess 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tommy E. Cole - Son 616 South Harmony Road - Newark, DE 19713 20b. Pleca of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ₺ Burial 2 □ Cremetion 3 □ Removel from Stete 5-10 4 ☐ Donetion 5 ☐ Other (Specify) Elkton Cemetery Elkton, Maryland 1997 21. Signature of Funerei Servica Licanses Hicks Home for Funerals, P.A. 103 W. Stockton Street - Elkton, MD 21921-5521 des M 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. **Physician** /Medicai Immediate Ceuse (Finel disease or condition resulting in deeth) eumonia Examiner e consequence of): Examiner that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying Ceuse (Diseese or Injury that initieted events rasulting in deeth) Lest and Due to (e consequence of) Box 68760, Physician/Medical the Due to (or es e consequence of) for use as been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. d 23b. Did tobacco usa contribute to the causa of death? 19 Yes 2 No 3 □ Probably 4 □ Unknown þ Records. Be Completed 24e. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? The law page 2 s 2 PNo 1 TYes 2 No Vital director 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 210 No 1 Yes 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) Certification: 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of After Hospital or Attending 5 Pending invastigation 1 Netural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicida 6 Could not be 28a. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) after 4 \(\text{Homicide} \) within 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete and pleca, and due to the causa(s) and mennar stated. Medicai 29a. Certifier To the 29b. Signature 29c. Licansa number 29d. Date signed (Month, Dey, Year) 30. Name an ed cause of deeth (Item 23e) (Type, Print) 31. Dete filed State

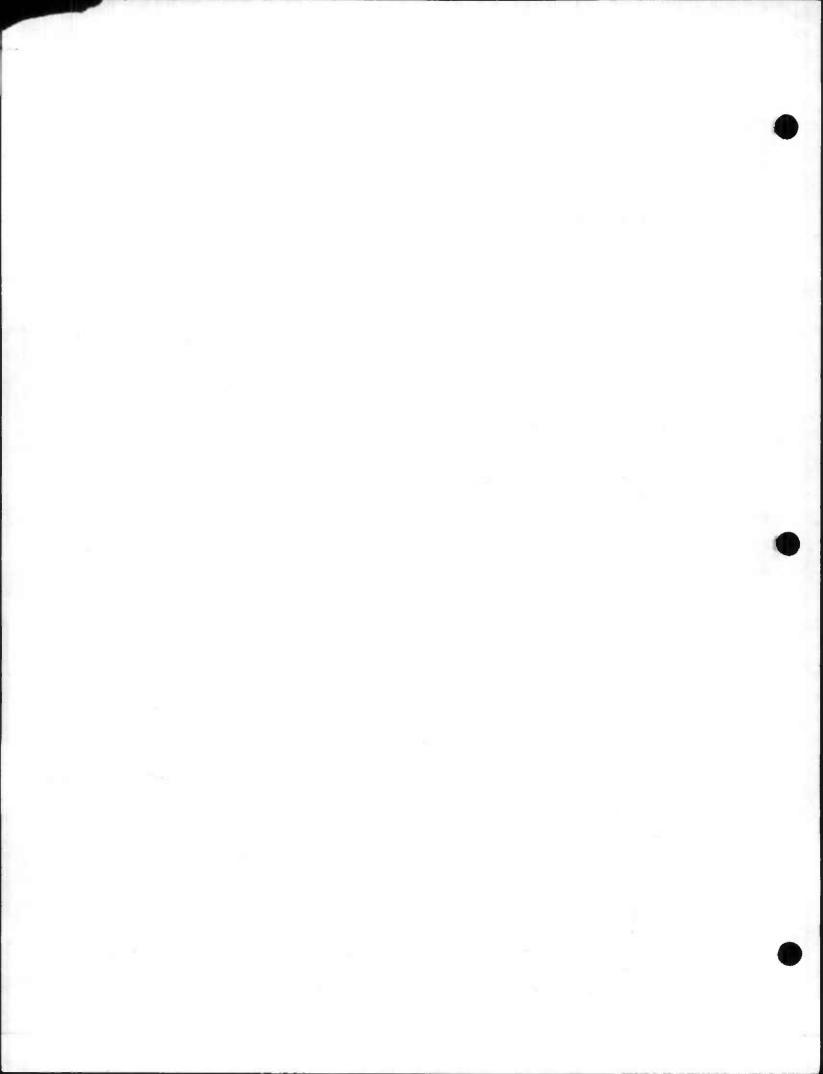
DHMH 16 Rev 6/95

Registrar

Fig. 13

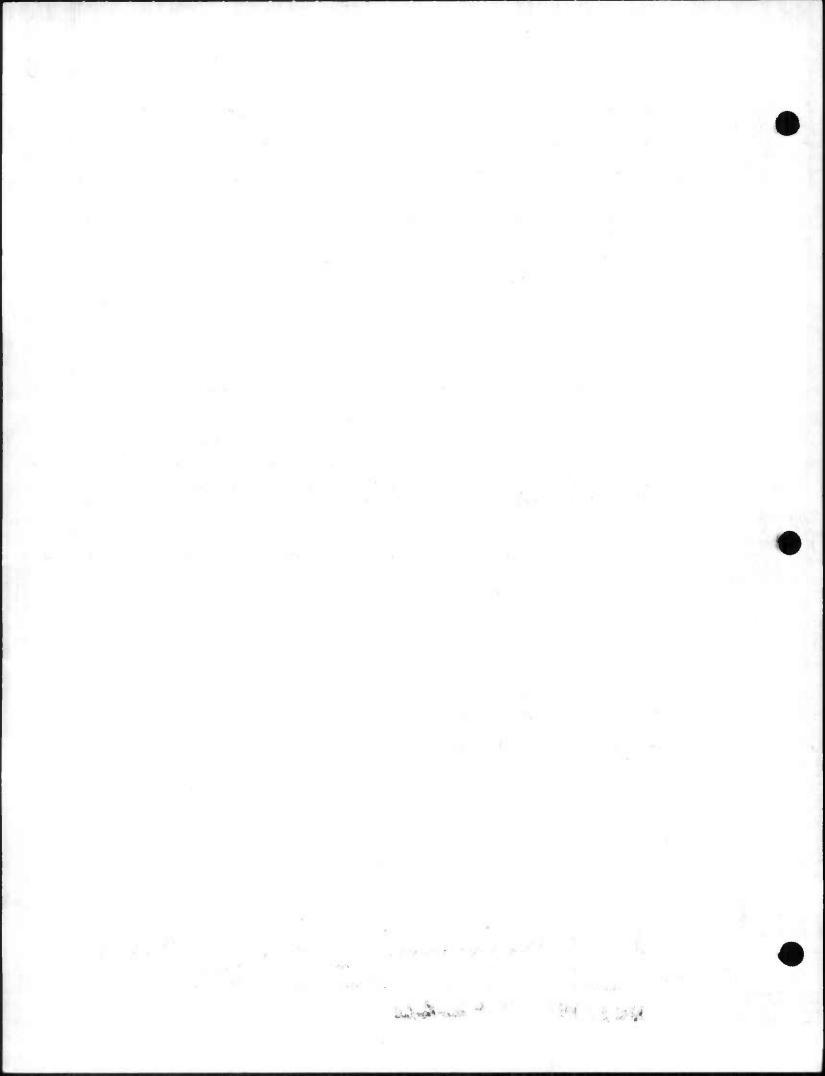
State of Maryland / Department of Health and Mental Hygiene

						Certificate o	f Death	Re	ig. No.	1/	1476	8
	Observator		1. Decedent's Neme (First, Middle, La	st)				2. Dete of Deetl Month		eer	3. Time of Deeth	
	Physici /Medi		HELEN MA	RIE COOK				MAY 1,		361	536 AM	
	Examir		4e. Fecility Neme (If not institution, give	e street and number)			4b. City, Town, or	Location of Deeth	4c. County of I	Deeth		
			LONG VIEW NURSIN				MANCHES			RROL		
	Funeral Director		5. Sociel Security Number 6. S 215-09-5319 Usuel Residence of Decedent	DM ODE	(In yrs. last birt	hday) If Under 1 Ye Months Dey			Year) 9. 1907		ece (State or Foreign y) (LAND	n
	ylend		10a. Stete 10b. County	1	Oc. City, Town	or Location				10	d. Inside City Limits	5
	a-f et	tor	MARYLAND BALTI	MORE			UPPERCO			1 ☐ Yes 2 No)	
	th with the 23a or 28	ai Director	10e. Street and Number 16001 DARK HOLLO	W ROAD		10f. Zip Code	2115		10g. Citizen of Whet Country? USA			
5-0020	filed within 72 hours after death with the Meryland hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examine must be notified at	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:	er in U,S.	13. Was Decedent of If Yes, specify Co	f Hispenic Origin? (S uben, Mexican, Puerl o <i>Specify:</i>	pecify Yes or No- to Rican, etc.)	No- 14. Race - American Indien, Bleck, White, etc. Specify: WHITE			
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Maryland 21	of to be	Be						ne (First, Middle, N	elden Sumame)			
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	thar Tie		NANCY E. RENNER,	**		5001 DARK					1006)	
ē,	-155		20e. Method of Disposition		20b. Plece of	Disposition (Name of			Oc. Location - City		n, State	_
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altimore,	permit. Pag Department Important: Il any Injury o		21. Signeture of Funerel Service Licer	100	PIOID	22. Name end Add		ELINE FUN			עויין	
<u>n</u>			Atlue 6	Other	e	1	TH MAIN ST	r, HAMPST	EAD, MD		4	
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	/Medical Examiner		Immediete Ceuse (Finel diseese or condition resulting In death)	0	Don en	tia, 1	Who beams				3 years	
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	he et ned fo	Physician/	Pert II. Other significant conditions of	ontributing to death but r	not resulting in	the underlying cause	given in Pert I.	23b. Dld tol	pacco uee contri	bute to t	the cause of death	?
S, P.O.	v requires that the death certificate be executed been signed by the ettending physician and should be detached for use as the bunal-transit	by Phy	ور: رو	ter viala	L'du			1 □ Ye	8 20 NO 3] Probe	ably 4 Unknow	'n
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	: The law cate has I	ပ်						1 □ Ye	s 2 No	1 🗆	Yes 2 Ho	
VII	ystclan: The is certificate director, page	Be	25. Was case referred to medical examiner?	Hospitel:				eth (Check only one				
5	Phys this ral di	: To	1 Yes 2 No 27. Menner of Deeth	1 L Inpatient		patient 3 DOA	Other: Wursing H	lome 5 Reside		Specify)		
0	ding h. After	tlon	1 Naturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Dey Y	ear) In	jury V	ork? □ Yes 2 □ No	200. 00301100 110	w injury occurred			
DIVISION	Atten r deal octor: by the	Certification:	3 Suicide 6 Could not b	28e. Plece of Injury	- At home, fen	m, street, factory, offic		28f. Location (Str	eet and Number o	or Rural	Route Number,	
É	after after d in t	ert	4 Homicide	building, etc. (Specify)			City or Town	State)			
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical (29a. Certifier Check only one) Certifying Ph	ysician: To the best of miner: On the basis of example and menner stete	eminetion end	death occurred et the for investigation, in my	time, dete end plece opinion, deeth occu	, end due to the ce irred et the time, de	use(s) end menne te end plece, and	er as stell	ted. he cause(s)	
	Vithin Fo th	Ne S	290. Signature and title of sertifier	The state of the s		29c. Lice	nse number	29	d. Date signed (A	Aonth, D.	ay, Year)	
			1 Mh	way		0	53165		5/1/	97		
			30. Neme end address of person who	completed cause of deet	h (Item 23e) (1							
			STEVEN SHAFFER N				IPSTEAD. M	D 21074				
Ī	Sta		31. Date filed (Month, Day, Year)	997 Augistrer	Signature	and ti						



State of Maryland / Department of Health and Mental Hygiene

			N-	Otate of Mary		tificate of		,	Reg. No.	97	14769	
П	Physic	ion	1. Decedent's Neme (First, Middle, Last)				2. Dete of Dee Month	-	Yeer	3. Time of Deeth	
J	/Medi		Owen H. Croggo	on					24, 199		6:00 P.M	
	Exami		4e. Fecility Neme (If not institution, give	street end number)			4b. City, Town, or Location of Deeth 4c. County of Deeth					
			9418 Worrell Ave	Lanham		rge's						
36	Funeral Director		5. Sociel Security Number 6. Se 217 09 6173 Usual Residence of Decedent	x 7. Age (In) My 2□ F 78	yrs. lest birthdey) Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey July 19			ce (Stete or Foreign y) ington D.C	
	pue *		10a. Stete 10b. County	10c.	City, Town or Loc	cation				100	d. inside City Limits	
	Ba-f sh	ctor	Maryland Prince Ge	eorge's	Lanham						X1√ Yes 2 No	
	F 22	Dire	10e. Street end Number			10f. Zip Code		1	log. Citizen of	Whet Country	13	
	1 23a	-a	9418 Worrell Ave.			2070	16		United	States	5	
0	I within 72 hours after deeth with the Maryland iene. Than "natural", or items 23a or 28a-f show the Medical Examinet must be recited.	Funeral Director	11. Meritel Stetus 1 Never Merried 2 Married	 Wes Decedent Ever in Armed Forces? Yes 2 □ No 		Vas Decedent of H Yes, specify Cubi ☐ Yes	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Ble	ce - American ck, White, et	c.	
21215-0020	tural',	ed by	3 ☐ Widowed 4 ☐ Divorcad	If Yes, Give Yeer or Detes: 42	-47				Specifi 16b. Kind of B	*****	ite	
1215	within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			petion during most of wor d)	king				
7			12		Brici	klayer				ructio	n	
Maryland	る草る	Be	17. Fether's Neme (First, Middle, Last)					ne (First, Middle, i		ne)		
7	d 2 should be th end Mental 7 is marked o traumatic eve	P	Owen F. Croggon 19e. Informent's Neme/Reletionship (Ty	mo Brint)	405 14-15-	A data (Ot		ude McGu				
Ma	DENE		Innes M. Croggon	Wife			end Number or Ru Ave. La				000)	
ē,	를 를 들		20e. Method of Disposition		b. Plece of Dispos	ition (Name of	ce) April	Dete L	20c. Location	City or Town	n. Stete	
E O			Buriel 2 Cremetlon 3 R 4 Donetion 5 Other (Specify)	emovel from Stete	cemetery, crem	etory or other plea	Cemeter	29, 1997				
Baltimore,	- 525		21. Signeture of Funeral Service/License			Maryland						
m	Depertiment in the particular		> mulul 2	Bula			Evans Fu					
1			23e. Pert1. Enter the diseese, or compli shock, or heart feilure. List only or	cetions that caused the d	eeth. Do not ente	r the mode of dyir	polis Rd	or respiretory err	Marylan est,	A	pproximete	
	Physician		Sites of Figure 10 and S. Elocotty of	io og at on occi into.							ntervel Between Onset end Deeth	
	/Medical Examiner		Immediate Cause (Final disease or condition	MESD-	PAELLO	MA.	RET	Lung	_	4	MONTHS	
		_	resulting in deeth)		o (or es e consequ							
	ted nsit	nin	e t	48BE	5-1081	5						
- 6.	axecu	Examiner	Sequentielly list conditions, if eny, leeding to immediate	Due to	o (or es e consequ	ience of):						
68760,	lificate be executed g physician end es the burial-transit	edicai	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	Due to								
	T 01 0	-	resulting in deeth) Lest	Due (c	(or es e consequ	ence or):						
Вох	andin r use	an/N										
E	deet he ett hed fo	sici	Pert II. Other significant conditions con	tributing to death but not	resulting In the und	derlying cause giv	en in Pert I.	23b. Did to	bacco uae co	ntribute to ti	he cause of death?	
, P.O.	res that the deeth cert igned by the ettendin be deteched for use	by Physician/N					DISEASE	1 □ Y	es 2 No	3 Probel	bly 4 Unknown	
Division of Vital Records,	requir	leted b	CAROPIC C	BRODUM	ù			24e. Wes e	n eutopsy ned?	eveils	eutopsy findings able prior to pletion of cause	
I Re	The law ate hes b page 2 s	Completed						101	s 2 No	of de	eth?	
Vita	ician: The certificate rector, pag	Be	25. Wes case referred to medical examiner?					th (Check only on	e)			
of	Physi this c	2	1 163 ZIM NO		☐ ER/Outpetlent		4 Li Nuising H	ome 5 Preside				
ion	Attending Physician: or death. ector: After this certific by the funeral director.	ation:	27. Menner of Deeth 1 Naturel 5 Pending 2 Accident investigation	28a. Dete of injury (Month, Dey Year,	28b. Time of Injury	28c. injun Work	yet k? Yes 2 □ No	28d. Describe ho	w injury occur	red		
Divis	5 4 5 5	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Plece of Injury - Albuilding, etc. (Spe	t home, farm, street	et, fectory, office		28f. Location (St. City or Town		er or Rural R	loute Number,	
	To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only one) 1	ician: To the best of my ker: On the basis of examinand menner steted.	nowledge, deeth on the land of	occurred at the timestigation, in my of	ne, dete end plece, pinion, deeth occur	end due to the ce red et the time, de	euse(s) end me ete end plece,	nner as stete and due to th	ed. e cause(s)	
	To the	-	29b. Signeture end title of certifier	•		29c. License	e number	2	9d. Dete signe	d (Month, Da	y, Year)	
1			I show a	rely My -	HALLA DIN	X- V	16/07		4.7	8-97		
111	1/11/		30. Neme and address of person who cor				PRES C	. Lnea	, NO	11		
10	y Iva		9306 MANHOM.	MUSICAL Y		HAMM,	my	2020	,y			
	Star Registra		31. Dete filed (Month, Dey, Year)	32. Registrer's Sig								



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death AMonth **Physician** LSAbe /Medical 4a. Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 5. Social Sacurity Number 7. Aga (In yrs. last birthday) . 60 Yrs. If Undar 1 Yaar If Undar 24 Hrs. 9. Birthplaca (Stata or Foreign 8. Data of Birth (Month, Day, **Funeral** Months Days (Month, Day, Yaar)
November 19, 1 ☐ M 2 🕅 F 579-62-1771 Yrs. Quaterrala Director 1936 Usual Rasidance of Dacedant the Maryland 10a State 10b. County 10c. City, Town or Location Gaithersburg 10d. Insida City Limits 28a-f show traumatic evant, the Medical Examiner must be notified at Montgomery Maryland Director 1 XYas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò U.S.A. 20879 Herna 23a 9917 Maple Leaf Drive deeth Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No Was Dacadant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, etc. Peges 1 and 2 should be filed within 72 hours effer in ont of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 ²□No Specify: Guatemalan 1 XYas 2 No by 3 Widowed 4 Divorced Specify: White Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Self-Employed Housekeeper 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama *(First, Middla, Maidan Sumama)* Maria Luisa Cuxil Be Ajmac Rodrigo 19a. Informant's Name/Ralationship (Type, Print)
Julia Ajmac Alarcon—Sister 19b Mailing Address (Steet and Number of Bural Route Number, Singar pwn, Steta, Zip Coda) permit. Peges 1 end 2:
Depertment of Health er
Important: If item 27 ia
any Injury or other trau 20b. Plece of Disposition (Nema of cematary, cramatory or other place)

Capillas Sernoriales 20a. Method of Disposition May Date 20c. Location - City or Town, Stata 1 Burlal 2 Cramation 3 Ramoval from State Las Charcas, Quaterrala 4 Donation 5 Othar (Spacify) 21. Signature of Funeral Service Licenses Rendon/Hale Funeral ! Annapolis Road, Home, MD 23a Part 1. Enter the diseasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximate Intarval Batween Onsat and Death **Physician** /Medical Immediate Ceuse (Final disaasa or condition rasulting in deeth) Examiner Due to (or as a consequance of) Physician/Medical Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last ettending physician end for use es the bunel-tran Due to (or as a consequence of): Records, P.O. Box 68760, Dua to (or as a consequanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the à 2000 3 □ Probably 4 □ Unknown signed l þ Completed 24a. Was an autopsy performed? 24b. Wera eutopsy findings available prior to complation of causa of deeth? peen After this certificate has funeral director, pege 2 2 X No Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was casa referred to medical examinar? Be 26. Piece of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yas 2 No P 1 Impatiant 2 ER/Outpetient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) Medical Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Panding Invastigation 1 Maturel 1 Yas 2 No 2 Accidant 3 ☐ Suicida 6 Could not be datarmined Placa of Injury - At homa, farm, streat, factory, offica building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ HomicIda 1 Certifying Physician: To the best of my knowledga, daath occurred et tha tima, data and placa, and dua to tha causa(s) and mannar as stated.
2 Medical Examinar: On the basis of axemination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to the causa(s) and mannar stated. 29e. Cartifian 29b. Signatura and titla of certifia; 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Name and addrass of person who completed cause of death (Item 23e) (Type, Print) MA 31. Data filad (Month, Dey, Year) Ragistrar's Signature State APR 29 199 Registrar

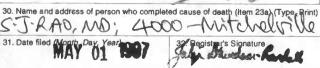
DHMH 16 Rev 6/95

in hands

State of Maryland / Department of Health and Mental Hygiene 4771 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** VALENCIA PALESTINE CHRISTIAN 3:00AM 27, 1997 APRIL /Medicai 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death EMERSON ST. PRINCE GEORGE'S BLADENSBURG If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1 □ M 2XX Months Hours Director 579-36-7884 66 JULY 11,1930 WASH., DC Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location or items 23a or 28a-f show 10d. Inside City Limits The Medical Examiner must be notified at XX Yes 2 No Director MARYLAND PRINCE GEORGE'S BLADENSBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5999 EMERSON ST. 20710 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. Pages 1 and 2 should be filed within 72 hours aftar 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify. BLACK ò 3 Widowed 4 Divorced Year or Dates. "natural" Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) DEPT. OF ADMINISTRATOR 12th 18. Mother's Name (First, Middle, Malden Sumama) 17. Father'a Name (First, Middle, Last) Be is marked JAMES T. BIAS 2 EDITH FOY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s
Department of Haalth ar
Important: if item 27 is
any injury or other trau BRENDA RANCE/ DAUGHTER 9322 FONTANA DR. LANHAM, MARYLAND 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LINCOLN MEMORIAL 5-2-97 SUITLAND, MD 21. Signatu he of Fuperal Service Licensee 22. Name and Address of FacilityMARSHALL'S FUNERAL 4308 SUITLAND RD. SUITLAND, MD 20746 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final INFARCTION disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last attending physician and for usa as tha bunal-tran Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Jinknown by been sign Be Completed 24a. Was an autopsy performed? 24b. Were eutopsy findings evailable prior to completion of cause of deeth? is certificata has b 1 Yes 2 KNO 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Wes case referred to medical 26. Place of Death (Check only one) 2 1 Nes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? Aftar 1 Netural 5 Pending investigation ector: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by aftar 4 Homicide To the Hospital c within 24 hours at To the Funeral D completally filled Descritiving Physician: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) and manner as steted.

Descritiving Physician: To the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar



D-34525

Raad; #220; Bowie-MD-20716

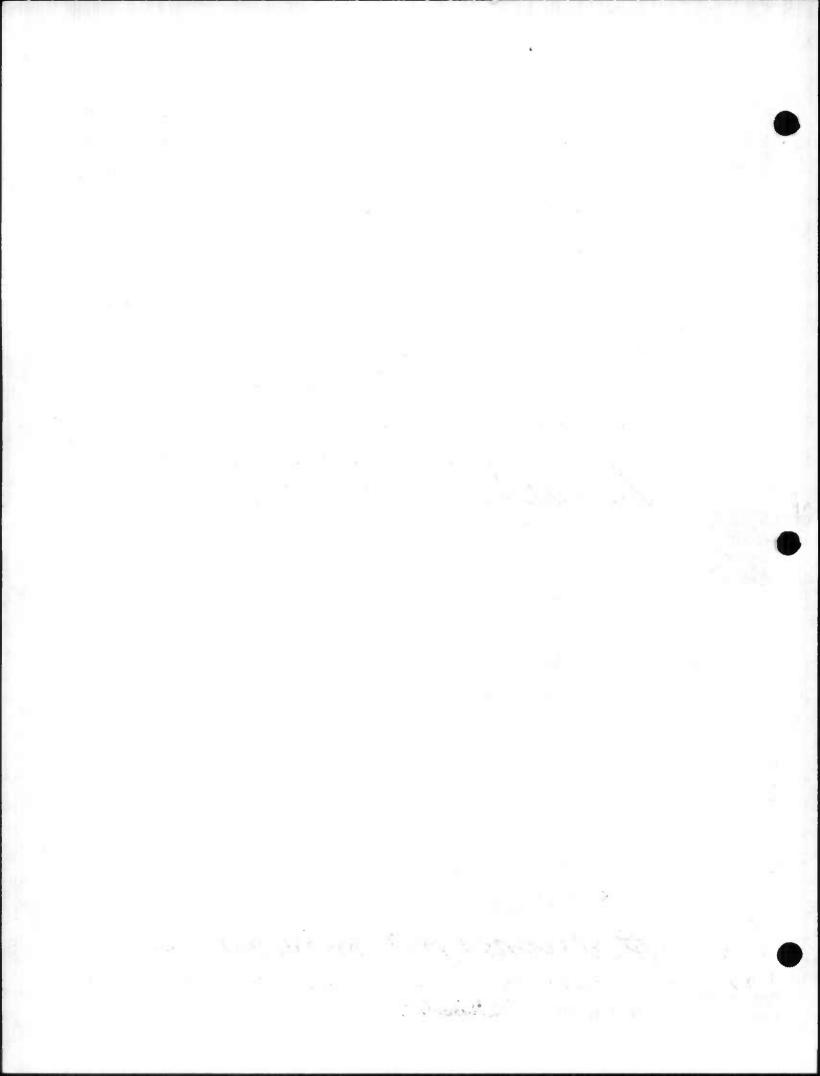
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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	/Med		4e. Facility Name (If not institution, gi		5.	Carlson_	4b City Town	April or Location of Dec	27, 1997					
	Exami	ner							10100011					
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П	Director		577-18-6490	1 X XM 2□ F 78	Yrs.	Months Day	rs Hours M	rs. 8. Data of E (Month, I 11/05	Day, Year)	Cou	intry)			
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	show		Maryland Prince G		10c. City, Town or I						10d. Inside City Limits			
	the Mary 28a-f sh	cto	raryland frince o	leorge s	Temple H	IIIS					t Yas 2□ No			
	or 28	Dire	10e. Straat and Numbar			10f. Zip Coda			10g. Citizen of	What Cou	intry?			
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	within 72 hours after death with the Maryland ene. than "natural", or Rems 23e or 28e-f show he Medical Examiner must be notified as	by Funeral Director	11. Maritel Stetus	12. Wes Decedant Ev Apped Forces?	er In U,S. 13	. Was Dacedant of	f Hispanic Origin? Jban, Mexican, Pu	(Specify Yas or It	No- 14. Ra					
20	or l	y Fi	1 Never Married 2 Married	1/LAYas 2 □ No		1□ Yas 2\XXN								
21215-0020	n 72 hours "natural",	D	3 Widowed 4 Divorced	Year or Datas: W					Орвен	Whit	:e			
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an	d be antal	B	John H. Carlsson						(First, Middla, Maiden Surnama) E. Evans					
Maryland	2 should be and Manta is marked raumatic e	Ĕ	19a. Informant's Name/Ralationship	(Type Print)	19h Mei	ling Address /Stre				State 7	in Code)			
X	2 6 8 8							noral noota rum	iber, Only or rown	, State, Zij	o Cooa)			
ē,	of Health Item 27 I		20a. Method of Disposition		20b. Pleca of Disc	osition (Nema of		Dete	20c. Location	- City or To	own. Steta			
JU O	Pages nant of nt: If Ite		1 Burial 2 Crametion 3	Removel from State	cematary, cr	amatory or othar p		5/07		,	Death George's Death George's Descripy Death George's Descripy Death George's Descripy Descript De			
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Ba	permit. Page Depertment of Important: If any Injury or once.		1 1 0 1	// 1.	,	George	P. Kalas							
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ox 68760,	ysicii	icai	Cause (Disaasa or Injury that initiated avants	c	a to (or as e consa	quance of):								
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Division		Certification:	3 Suicida 6 Could not b datamined		- At home, ferm, s	traat, factory, office	9	28f. Location City or To	(Streat and Numb	ber or Run	al Routa Number,			
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	To the Hospital or within 24 hours afti To the Funeral Dir completely filled in	icai	Check only 2 Medical Exam	ysician: To the best of n	ny knowledge, daa kamination and/or ir	th occurred at the	time, data and pla-	ca, end dua to the	a causa(s) and ma	anner as s	iteted.			
	the the the	29a. Certifying Physicfan: To the best of my knowledge, daath occurred at the time, data and placa, end dua to tha causa (Check only one) Certifying Physicfan: To the best of my knowledge, daath occurred at the time, data and placa, end dua to tha causa (Check only one) Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, end dua to the causa of the control of th									d place, and dua to tha causa(s)			
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1	X		30. Nama and addrass of person who					11 14000	TNOTON C	0 00	100			
7	4/		VETERANS AFFAIRS 31. Data filed (Month, Dey, Year)				KEEI, N.	W. WASH.	INGION,D	L 204	22			
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	11091311		may I of you	80										



State of Maryland / Department of

Certificate of

	2. Date of Death		3. Tir	ne of	Dea	ath	
f Death	Reg. No.				-	-	-
	Mental Hygiene	97		L	7	7	-

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

.Funeral Director

28a-f show 6 items 23a death be filed within 72 hours after natural', or

permit. Pages 1 and 2 should be filed within 7, Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, the Internation once.

Baltimore, Maryland 21215-0020

P.O. Box 68760,

of Vital Records,

Division

Physician /Medical Examiner

The law requires that the death certificate be executed the buriel-transit signed by t certificate Attending Physician: Be Certification: To this spital or Attending Physhours efter death.
neral Director: After this y filled in by the funeral di To the Hospital within 24 hours e To the Funeral C

Month Day ESTELLE CHEW MAY 04 1997 0630 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey Year) | Min. | March 11,1897 5. Social Security Number 6 Sex 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country)
Maryland 1□ M 20XF 100 213-74-5874 Yrs. Usuel Residence of Deceden 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 189 Wilson Road 20639 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Maritel Status 14. Rece - American Indian, Biack, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black by 3X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Eiementary/Secondary (0-12) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Sarah Parker 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daisy M. Chew/Daughter 1407 Shepherd St. N.W. Washington, D.C. 20011 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 △Buriai 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Brown's Church Cem. 5/8/97 Port Republic, MD 21. Signature of Funerei Service Licensee 22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678 Sewell eencer 23e. Part . Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final RESP - FAILURE

Due to (or as a consequence of): disease or condition resulting in death) Examiner CHR. OBST. PUL. DISEASE Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Physician/Medical Due to (or as a consequence of): HEADT FAILURE Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown ð Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicei examiner? 28. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide edicai 29a, Cartifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

MD

32 Registrar Signature

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

R. PATEL

31. Date filed (Month, Day, Year)

State

Registrar

DHMH 16 Rev 6/95

110 HOSP. DR, # 303, PR. FREDERIYL, MD 20678

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State of Maryland / Department of Health and Mental Hygiene

JAMES ALFORD COOLEY Amend #8,12-10-27, drw Certificate of Death

APRIL 26, 1997

	1. Decedent's Name (F	irst, Middle, Last)
Physician /Medical	James	Alford
Examiner	4a. Facility Name (If not	institution, give s
	1 1 0 0	

2. Date of Death Month Δ P R T T.

Funeral Director

permit. Peges 1 and 2 should be filed within 72 hours effer c Depertment of Heelih and Mentel Hygiene.

Department of Heelih and Mentel Hygiene.

any Injury or other treumatic event, the Wedgel Examinet once.

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

Physician/Medical Examin Medical Certification: To Be Completed by

To the Mospital or Attending Physician: The law requires thet the death certificate be executed within £2 hours attent death. To the Funeral Director. After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for usa as the bunial transit 10, 14

Division of Vital Records, P.O. Box 68760,

James KIIO	Iu co	отеу					AFKII	1 23, 1	. 9 9 1	7 . ZWF . P
4a. Facility Name (If not institution, gi	ve street and nu	imber)			4	b. City, Town, o	or Location of Death	4c. County	of Death	
110 SUNDERLAN						SUNDER		CALV		7.3
247 34 0638	Sax MAXM 2□ F	7. Aga (In yrs.	. last birthdaj Yrs.		Days	If Under 24 H Hours Mi	n. (Month, Da	th y, Year) 10 7-1927	9. Birthpla Country FL	ce (Stata or Foreign y)
Usual Residence of Decedent			15							
MD 10b. County Calver	t		ity, Town or I iderlai						100	d. Inside City Limits 1 ☐ Yas ♣️ No
10e. Street and Number				10f. Zip C	ode			10g. Citizen of V	What Country	v?
110 Sunderland D	rive				2068	19		USA	That Goald	,
11. Maritai Status	12. Was Dec	edent Evar in L	J,S. 13	. Was Decedar	nt of Hi	spanic Origin?	(Specify Yes or No	- 14. Rac	e - Amaricar	n Indian,
1 Nevar Married 2 Married 3 XWidowed 4 Divorced	Armed For 1 Types If Yes, Gi Year or D	orces? 2□No ive Dates: 1945	5-48	If Yes, specify 1 ☐ Yes 2x		n, Mexican, Pue Specify:	erto Ricen, etc.)		ck, White, et v: whit	
10e. Street and Number 110 Sunderland D 11. Marital Status 1 Nevar Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12) 17. Father's Name (First, Middle, Las Jack	ducetion		16a. Dec	edent's Usual (Occupa done o	ation furing most of w	vorking	16b. Kind of B	usiness/Indu	stry
Elementery/Secondary (0-12)	College (1-4or 5+)		onautic				Aeroi	nautic	S
17. Father's Name (First, Middle, Las	t)						eme (First, Middle,			
Jack		Cooley	7			Addeli		A		bb
19a. Informent's Name/Relationship		ondous					Rural Route Number		State, Zip C	Code)
Charlotte R. Atki	nson/st	20b.	Place of Disc	osition (Name	of	oodyear	Date	338 20c. Location -	City or Tow	n. State
1 Burial 2 Cremation 3 [4 Donation 5 Qther (Speci		State	cematery, cr	ematory or othe litan C	arplac		4-28-97	Alexand		
21. Signature of Fuperal Service List		- 4	2	22. Name and	Addres	s of Facility			•	
M. Ah.	11	Ho				•	me, Owin	gs, MD	20736	
Part1. Enter the disease, or con shock, or heart failure. List only	plications that of	cessed.He dea	th. Do not e	nter the mode	of dyin	g, such as cerdi	ac or raspiratory a	rest,	A	Approximate Interval Between
Immediate Cause (Finel									C	Onset and Death
disease or condition resulting in death)	a. Arte				rdi	ovascu	ılar Dis	sease		
		Due to (or as a cons	equence or):						
Sequentially list conditions, if any, leading to immediate	D	Due to (or as a conse	equence of):						
if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	C	Due to /s	N 00 0 0000	augnoc of						
resulting in death) Last	d	Due to (c	or as a conse	equance of):					1	
Part II. Other algnificant conditions	contributing to d	eath but not res	sulting in the	underlying ceu	ise give	en in Part I.	23b. Did 1	obacco use co	ntribute to t	he cause of death?
							10	Yes 2 No	Proba	bly 4 Unknown
								an autopsy rmed?	24b. Were	autopsy findings
								PECTION	comi	pletion of cause
			-				101	ras XXVo	10	Yea 2□ No
25. Wes cese referred to medical examiner? **Control of the contr	Hospitel:		150:0		Othe	AF:	eath (Check only o			
	1 1 1		ER/Outpatie		1	4 □ Nursing	Home 5 Resid		er (Specify)	
27. Manner of Death Value 5 Pending 2 Accident investigation		of Injury th, Dey Year)	28b. Time Injury	of 28c	i. Injury Work 1 □ 1	rat ⟨? Yes 2 □ No	28d. Describe h	now Injury occur	red	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of Injury - At h ing, etc. (Speci		treet, factory, o	office		28f. Location (S City or Tox	Straet and Numb vn, Stete)	er or Rural F	Route Number,
29a. Certifier 1 Certifying Processing (Check only one)	miner: On the b	best of my kno asis of examina ner stated.	owledge, dea ation and/or I	th occurred at nvestigation, in	the tim	e, date end plac pinion, deeth occ	ce, and due to the curred at the time,	ceuse(s) and me date and place,	enner es stat and due to th	ed. ne ceuse(s)
27. Manner of Death **Line	11	1		29c. L	icensa	number		29d. Date signe	d (Month, Da	ay, Year)

O.C.M.E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201

32. Registrar's Signature

Hali Davidson Rarlall

State Registrar

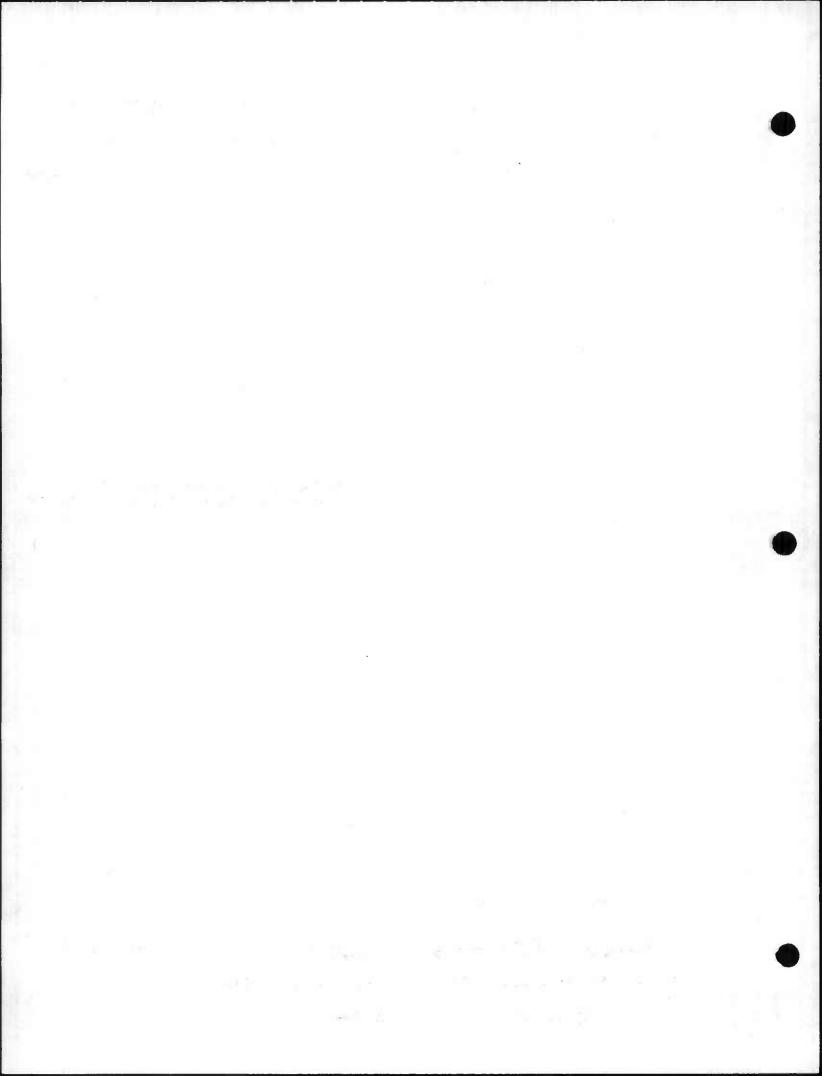
Locke M. D.

State of Maryland / Department of Health and Mental Hygiene

14775

	_				Ce	rtificate	of	Death			Reg. No.	0 1	1 7 1 1 4
Physician /Medical	1	1. Decedent's Name (First, Middle Jean	e, Last)	Marie		De	1aì	nanty		2. Dala of Do		9 ⁷ ear	3. Time of Death 2:15A.
Examiner	rľ	4a. Facility Name (If not institution 4314 Briggs Cha						4b. City, Tow Belts		cation of Deal		y of Death CE GE	orge's
Funeral Director		5. Social Sacurity Number 578-24-3232 Usual Residence of Decaden	6. Sex 1 □ M X XF	7. Age (In yrs. I	70 Yrs.	If Undar 1 Months	Year Days	If Undar 2	4 Hrs. Min.	8. Date of Bi Month, D DeC •	6,1926	Cour	olaca (Stata or Forai olty) ington, D.
and show lifted at		10a. State 10b. County	e George'		.Town or Lo							1	0d. Inside City Limit
r items 23s or 28s-f sho		10e. Street and Number 4314 Briggs Cl	naney Roa	nd		10f. Zip 0	ode 70!	5			10g. Citizen of Unit	What Cour ed St	
al', or item Examiner.	2	11. Marilal Status 1 Never Married 2XXMarri 3 Widowed 4 Divorced	12. Was Der Armed F 1Yes If Yes, G Year or		1	Was Dacede 1 Yes, specif 1 □ Yes X			n? (Spa Puerto	acify Yes or No Rican, etc.)	14. Ra Bla Specil	ce - Americ ick, White, by: W	
I other than "natural", went, tre Medical Ex.	The state of the s	15. Decadent (Specify only highes Elementary/Secondary (0-12) 12	t grada completed	(1-4or 5+)	(Give life. I	dent's Usual kind of work DO NOT use ager	Occup done retire	pation during most of d)	of worki	ing	16b. Kind of B		one Co.
item 27 is marked other than other traumetic event, training To Be Comp	3 1	7. Father's Name (First, Middle, & Roy	.ast)	N	Marcey			18. Mothar's		(First, Middla	, Maiden Sumai	ma)	Birch
item 27 is ma other traums	19a. Informant's Name/Relationship (Type, Print) Thomas Delahanty (Husband) 19b. Malling Address (Streat and Number or Rural Route Number of Rural Route									l Route Numb	mber, City or Town, State, Zip Code)		
Important: If iten any injury or oth once.	2	t0a. Method of Disposition 1 □ Burlal 2 ② emation 4 □ Donation 5 □ Other (Sp	3 □Ramoval from ecify)	State	emetery, cren	natory or oth	ar plac		4/29	Date 9/1997	20c. Location Alexan		wn, Stata Virgini
rsician ledical aminer		23a. Part1. Entar the diseasa, or shock, or heart fallure. List of immediata Cause (Final diseasa or condition resulting in death)	composition that that only one china on	Lunc	. Do not ente	100 Por	wde of dyin	r Mill	. Rd	. Belt	al Home sville, rrest,	, P.A Mary	and 2070 Approximate Interval Between Onset and Death
ettending physician and for use es the burial-transit	t	Sequentially list conditions, any, leading to immediate ause. Enter Underlying Sause (Disaase or Injury hat Initiated avents esulting In death) Last	b	BREMS Due to (or CARO)	as a conseq	uenca of):		y ha	as				
d by the setached		art II. Other significant condition	a contributing to d	leath but not rasul	lting in the ur	nderlying cau	se giv	en in Part I.					the cause of deal
2 should pleted										24a. Was	an autopsy med?	ava	ra autopsy findings illable prior to npletion of cause feath?
		E Wassers of section of the									ras XX No	1	Yes XXNo
	ľ	5. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	Hospital:	Inpetiant 2 E	R/Oulpatient	3□ DOA	Oth	or:		(Check only o	ne) denca 6 □Oth	or (Canaih	d
ctor: After this y the funeral of the funeral of the floation: T	2	7. Manner of Death 1 kinatural 5 Pending 2 Accident invastiga	28a. Data (Mon	11.11	28b. Time of Injury		Injun Worl	y at k?	2		now injury occur		,
2 D =		3 ☐ Suicida 6 ☐ Could no 4 ☐ Homicide determin	ed 28a. Place	of Injury - At honing, etc. (Specify)	ne, farm, sira	al, factory, o	ffica		2	28f. Location (: City or Tox	Street and Numb vn, State)	er or Rura	Route Number,
To the Funeral Direction of the Funeral Direct		<u> </u>	Physician: To the kaminer: On the b and man	best of my know esls of examination er stated.	ledga, daath on and/or inv	occurred at lestigation, in	ha tim my of	ne, data and p pinion, death	olaca, a occurra	nd dua to tha	cause(s) and ma dala and placa,	anner as st and dua lo	ated. the cause(s)
To the F	2	9b. Signatura and title of certifiar Figher	M		6	29c. L		number			29d. Date signe April 2		
2	3	D. Nama and address of person w Isabella Marti		sa of death (Item : 8379 Cl		Print)			ary	land 20			
State Registrar	3	1. Date filad (Month, Day, Year)		Registrar's Signatu					_				
Registrar		TAIL TAIL	2 1997 1	gunar	autason.	-Nanaso	6						

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate o	f Death		Reg. No.		14/10
Physic	ion	1. Decedent's Name (First, Middle, L.	ast)					2. Date of De	eath Dey	Yeer	3. Tima of Death
/Medi			Beverly	La	u		Dodds	April	30, 199		11:00 AM
Examir		4a. Facility Name (If not Institution, gi	ve street end number)				4b. City, Town, or	Location of Deet	h 4c. County	of Death	
4			ne				Bowie		Prin	nce Ge	eorge's
Funeral Director			Sex 7. Ag 1□M 2♥F	e (In yrs. lest t	virthday) Yrs.	If Under 1 Yas Months Day			oy, Year) 8, 1930	9. Birthple Count Min	ace (Stata or Foreign ry) NESOta
anyland show		10a. Stata 10b. County		10c. City, To	wn or Loc	eation				10	d. Insida City Limits
The M 28a-1 Notifie	ector	Maryland Prince	George's	Bow	ie	10f. Zip Cod8			100 Cities of	45-4-0	1X Yas 2□No
6 23	Funeral Director	4008 William Lane				2071			Unite	d Stat	tes
d 2 should be illed within 72 hours after dea th and Mental Hygiene. It's merked offer then "neturel", or items traumatic event, the Medical Examiner or	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Armed Forces? 1 Yas 2 1 If Yas, Giva Year or Dates:	Evar In U,S. No		Vas Decedant o Yas, specify Cu ☐ Yes 2 🛣 N	Hispenic Origin? (sban, Maxicen, Pue	Specify Yas or No to Rican, atc.)	Specify	e - Amarica ck, Whita, a '' Whi	itc.
72 hr Partur Bical	Completed	15. Decedent's E (Specify only highest gi	ducation	16	a. Deced	ent's Usuel Occ	upation e during most of wo	orking	16b. Kind of B	usiness/Inde	ustry
Man of the	npie	Elementery/Secondery (0-12)	Coilege (1-4or 5	5+)							
B C S C	S	12			Sale	es Perso			Childre		lothing
d off	B	17. Fether's Name (First, Middle, Las					18. Mother's Ne	me (First, Middle			
thould b rd Ments marked marked	1º	Charles S	Scribner				Cora	J.	Gilman	1	
2 str. and ts ma		19a. Informent's Neme/Relationship			disc		et end Number or R			Stete, Zip (Code)
		David D. Dodds	Sc				Drive, Cor		94521		
Pages 1 nent of H ant: If its ary or of		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				sition (Name of atory or other p e Crema		Data 5/2/97	Beltsvi	-	m, State Maryland
permit. Pages 1 as Department of Hea Important: If item 3 any injury or other once.		21. Signature of Funarai Service Lice	nsee La	× ×	Ra	pp Fune	rass of Facility ral Servi Avenue, S	ces, P.	Α.		
and the same		23a. Part1. Enter the disease, or con shock, or heart failure. List only	pilcations thet caused	the deeth. Do	not ente	r the mode of d	/ing, auch es cerdia	c or respiratory	errest,		Approximate Interval Between
Physician /Medical Examiner	J.	Immediate Cause (Finel disease or condition resulting in deeth)	a. M	Due to (or es	1.1)?	4	CGO			Conset and Death
xacuted and I-transit	Examiner	Sequentielly list conditions, If any, leeding to immediate	b. —————	Due to (or es	consequ	uance of);					
eath certificate be executed attending physician and for use es the burtal-transit	Medical E	Sequentielly list conditions, If any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting In death) Last	C	Due to (or es a	consequ	ance of):					
death cert	Physician/N	Pert II. Other eignificant conditions	d	ut not resulting	In the un	dedving ceuse	riven in Part I	23h Did	tobacco usa co	ntribute to	the causs of death?
d by th	y Phys							/	Yes 2□ No		ably 4 Unknown
requir seen s should	Completed by							24a. Was	an autopsy ormed?	com	re autopsy findings ilable prior to apletion of ceuse eath?
The ate h	Sol							10	Yes 2 No	10	Yas 21 No
ysician: The law s certificate has t director, page 2 s	Be	25. Was case referred to medical examiner?					26. Place of De	ath (Check only	one)		
Physician: this certific	To	1 ☐ Yes ¾CXNo	Hospitel: 1 Inpatie	nt 2 ER/C	Outpatient	3□ DOA	ther: 4 Nursing I	Home 5 X Resi	idence 8 Oth	er (Specify))
To the Hospital or Attending Ph within 24 hours after death. To the Furseral Director: After thi completely filled in by the funeral	Certification:	27. Menner of Death 1) Naturel 5 Pending 2 Accident Investigation		ry Y Year) 28b.	Time of Injury	28c. In W	ury et ork? ☐ Yes 2 ☐ No	28d. Describe	how injury occur	red	
bal or Att	Certifi	3 Suicide 6 Could not be determined	28e. Piece of Injusting, etc.	ury - At home, c. (Specify)	ferm, stre	at, fectory, offic		28f. Location (City or To	Street end Numb wn, Stete)	er or Rural	Route Number,
To the Hospital or Attending R within 24 hours after death: To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the bast of miner: On the basis of end manner sta	examination a	ge, death ind/or inva	occurred at the astigation, in my	time, dete end plec opinion, deeth occ	e, and due to the urred et the time,	cause(s) and ma dete and place,	anner as sta and due to	ited. tha causa(s)
	Me	29b. Signatura and title of certifiar	Sa	~		29c. Lica	nsa numbar		29d. Deta signa		
15	-	30. Name and eddress of person who	nomplated server of d	noth /lton- oc	(T 7		4 40 2		April:	30, 19	397
Sta	†a	31. Dete filed (Month, Dev. Year)	Dobin	32	331	SUL	perior	LN	Bown	e, 1.	nd 20715
Sta Registr			2 1997 ▶	icha Dav	idson-	Mandall					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Death 3 Time of Deeth **Physician** ANN DURBIN 645pm 23 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Suburban Hospital Montgomery

9. Birthplace (State or Foreign Country) Bethesda If Under 24 Hrs. 7. Age (In yrs. lest birthdey) If Under 1 Year 5. Social Security Number **Funeral** Deys Min. 1 M 2 F Months Hours Yrs Director 772-03-2922 87 Aug. 20, 1909 Lithuania Usuel Residanca of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Ineide City Limits Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? WITH 8315 North Brook Lane death Funeral Apt. 605 U.S.A. 20814 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Reca - American Indien, permit. Pages 1 and 2 should be filed within 72 hours efter. Department of Health end Mental Hygiene. Important: if flem 27 is marked other than "naturel", or free any injury or other traumating account. Bleck, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify 3 ₩idowed 4 Divorced White Completed 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 10 Bookkeeper Railroad 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Rokas Kutka Marcele Sorockaite 19a. Informent's Neme/Reletionship (Typa, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) William P. Durbin, Jr. 10003 Thornwood Road Kensington, Maryland 20895 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State Buriel 2 Crametion 3 Ramovel from Stata 4 □ Donetion 5 □ Other (Specify) Mt. Carmel Cemetery 4/28/97 Belleville, Illinois 21. Signature Juneral Servica Licansee 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 23a. Part. Enter the disease, or complications that cause the death. Do not anter the mode of dying, such as cardiac or respiratory errest,

Approximate Approximete Intervel Between Onset end Deetl **Physician** /Medical Immedieta Ceuse (Finel infarctions, recurrent Myocarial diseese or condition resulting in death) **Examiner** Dua to (or es a consequence of): orona my SI the burief-transit Sequentielly list conditions, if eny, laeding to immediate cause. Entar Underlying Causa (Diseesa or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Records, P.O. Box 68760. atherosclerosis the attanding physician generalize Physician/Medical Due to (or as e consequance of): use as for Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? à Congestive hourt failure 1 Yes 2 No 3 Probably 4 Unknown þ Old myocardial infarctions 24b. Were eutopsy findings evallable prior to completion of cause of deeth? Completed 24e. Wes en autopsy performed? peen certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetlent 3 ☐ DOA this Certification: 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury et Work? 5 Panding investigation 1 Neturel within 24 hours efter death.
To the Funeral Director: Af
completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Spacify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Steta) 4 Homicida To the Hospital Certifying Physician: To tha best of my knowledga, daath occurred et tha tima, data end place, and due to the ceuse(s) and mannar as steted.

| Certifying Physician: To tha best of my knowledga, daath occurred et that tima, data end place, and due to the ceuse(s) and mannar as steted.

| Medical Examiner: On the bests of examinetion end/or invastigation, in my opinion, daath occurred et the tima, date end place, end due to the causa(s) and mennar stated. Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 410 Rockledge Drive; Bethesda MD 20817

State Registrar

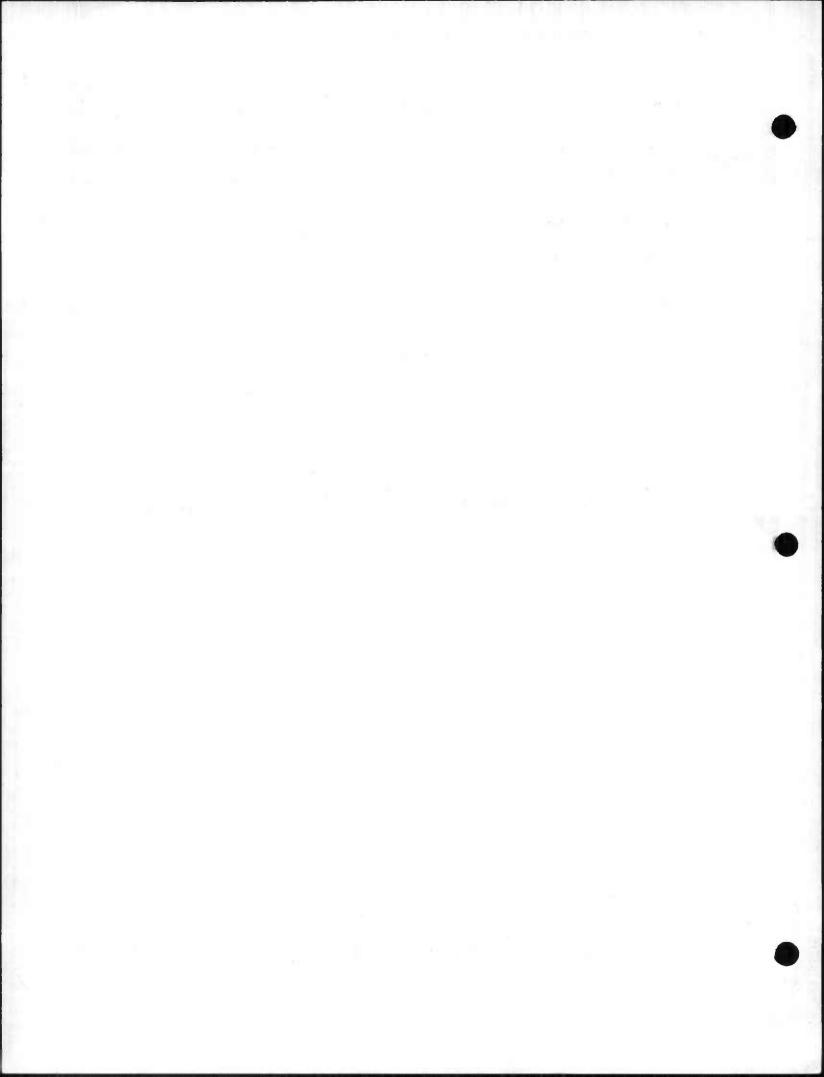
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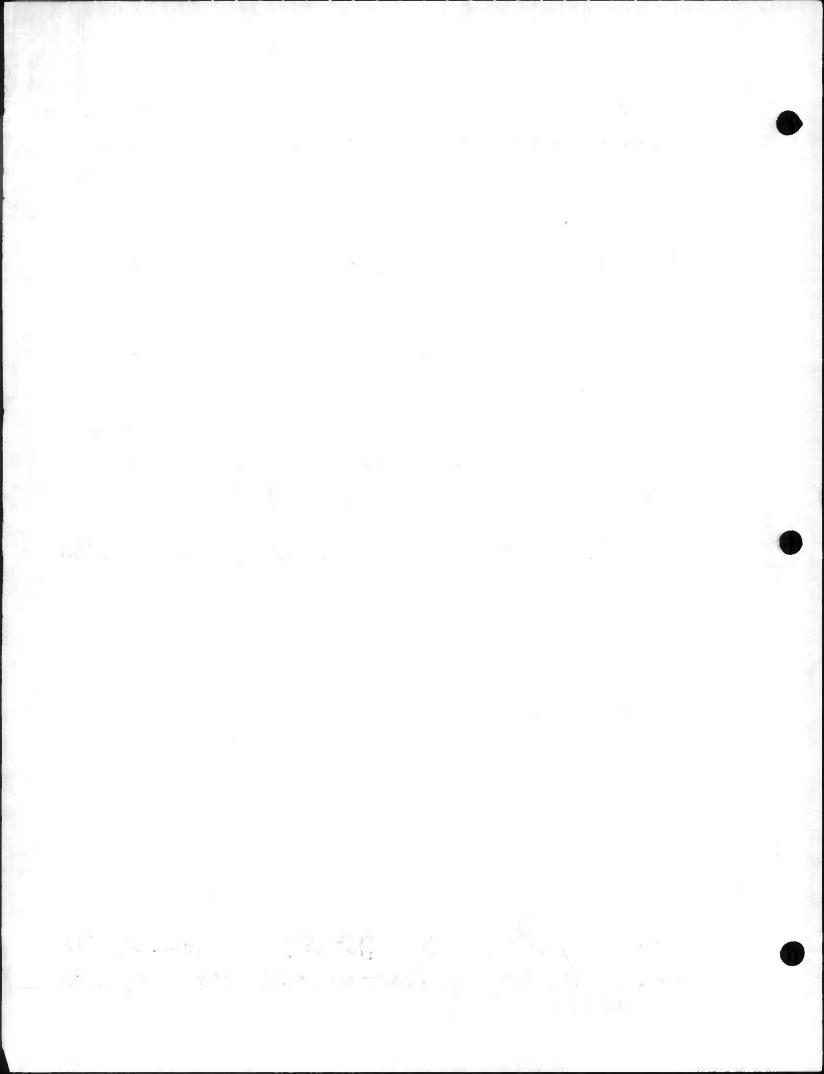
31. Data filed (Month, Dey, Year)

ROMEO, MD 32. Registrer's Signature Shia Savidron



State of Maryland / Department of Health and Mental Hygiene 97

						,		Cert	ificate of	Death		Reg. No.	21	14/18
	Physic	an	1. Decedent's Name (First	, Middle, Las	t)						2. Date of Dea		Yaar	3. Time of Death
J.	/Medi		James J. D	-							April 3			1:15 AM
1	Examir	ner	4a. Facility Name (If not in							4b. City, Town, or	Location of Death	4c. County	y of Death	
L			Montgomery 5. Social Security Number				24 E 2-46	6.1	If Under 1 Yaar	Olney			gomer	
	Funeral Director		028-22-8362 Usual Residence of Deced		M 2□F	Aga (In yrs.			Months Days			h, Year) 1929	Cour	place (Steta or Foreign ntry) achusetts
	M M			County		10c. Cit	y, Town	or Loca	tion				1	IOd. Inside City Limits
	the Maryland 28a-f show sottlied at	ctor	Maryland Mo	ntgome	ry	В	rook	evil	lle					1 ☐ Yes 2 ☐ No
	6 22 5	Director	10e. Street and Number						10f. Zip Code			10g. Citizen of	What Cour	itry?
	eth v		19104 Mount	Airey					2083			U.S.		
	er de Itema Der D	Funeral	11. Marital Status	T Maritan	12. Was Decedar Armed Forcas	2		13. Wa	s Decedent of as, specify Cut	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No- to Ricen, atc.)	14. Rad Bla	ca - Amaric ck, White,	
21215-0020	72 hours after death with the Marylar 'natural', or Items 23e or 28e-f show idles! Examiner must be notified at	by	1 ☐ Naver Married 2 3 ☐ Widowed 4 ☐ Di		1 X Yes 2 If Yes, Give Yaar or Dates	1949	-52	1	Yes 2√ No	Specify:		Specif		
2-0	"natura edical	ted		cedent's Edi	ucation de completed)		16a. [eceder	nt's Usual Occu	pation	44	16b. Kind of B	Whit usiness/Ind	
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7	d 2 should b h and Menta 7 is marked fraumatic e	To	Francis F.]		vne Print)		19h I	Meiling	Address (Stree	Margar	et Har	7	State 7in	Cadal
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altimore,	T. F. E. E.		20a. Method of Disposition	,			lace of [Dispositi	ion (Name of tory or other pie		Date	20c. Location		and 20833 own, State
Ĕ	Pages nent of i ant: If he ary or o		1⊠ Burial 2 □ Crem 4 □ Donation 5 □ Of			9					5/2/07	dlarer C	Enwine	g,Maryland
alt	permit. Paper Department of Important: If it any injury or 9000.		21. Signature of Funeral S	ervice Licens	sae			22. N	lame and Addre	ess of Facility				g, mary ranu_
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	1100		23a. Part1. Enter the diser shock, of heart failure	ase, or comp a. List only o	lications that cause ne ceuse on each	ed the deat	n. Do no	t entar i	the mode of dy	ng, such as cardia	c or respiratory ar	rest,	riary.	Approximata Interval Between
	Physician /Medicai													Onset and Death
	Examiner		Immediate Cause (Final diseasa or condition resulting in death)		a. #1/	KA	CE	KE	13KAZ	ten	UKKH	AUE		777YS
		-e-				Due to (o	rasaco	nseque	nce of):					
	outed ansit	Examiner	Cognostially list conditions		b	Dua to (o	7 9 5 9 00	neadle	nce of):					
o,	an en		Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or Injury	ė		Dua to (o	as a co	iiseque	nos or).					
68760,	cete be executed physician end s the burief-transit	Medical	Cause (Disease or Injury thet initieted events rasulting in death) Last	5	c	Dua to (o	as a co	nsequar	nca of):					
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Box	eath ce ettendir for use	Physician/			d				-					
o	the de	iysic	Part II. Other significant or			but not resi	ulting in t	he unde	orlying cause gi	ven in Part i.	23b. Did to	obacco use co	ntribute to	the cause of death?
<u>.</u>	law requires that the deses been signed by the espould be detached for	by Ph	HYPERTH	37/SU	\sim						101	es 2 No	3 Prob	bably 4 Unknown
rds	a sign	g p									24a. Was a	in autopsy	24b. We	ere autopsy findings
Records,	s been si	Completed									perfor	mad?	cor	allable prior to mpletion of cause death?
ř	0 - 6	E O									1 U Y	es 20 No	+	Yes 20 No
Vita	ysician: The s certificate director, pag	Bec	25. Was case referred to m	edicel						26. Place of Dea	ath (Check only or			
5	Physici this ce al direc	2	examiner?	ŀ	lospital: Inpat	ient 2 🗆	ER/Outp	atient	3□ DOA OH	ner: 4 Nursing H	loma 5 ☐ Rasid	ence 6 Oth	ar (Specify	()
			27. Manner of Death 1 □ Natural 5 □ I	Pending	28a. Date of In (Month, D	ury 9 <i>y Year)</i>	28b. Tin Inju		28c. Inju Wo	ry at rk?	28d. Describe h	ow injury occur	red	
Sio	deeth. ctor: A y the fu	cati	2 Accident	nvestigation Could not be					M 1 🗆	Yes 2 □ No				
DIVISION	or Attendeter deeth Director:	Certification:		determined	28e. Place of Ir building, e	ijury - At ho tc. (Specify	me, farm	, street	, factory, office		28f. Location (S City or Tow		er or Rura	I Route Number,
	spital cours nerai / filled		29a. Certifier	rtifying Phys	ician: To the best	of my know	viedne r	leeth oc	curred at the ti	me, date end place	and due to the c	ause(s) and me	onner ee et	heted
	To the Hospital or A within 24 hours effer To the Funeral Dire completely filled in b	edical	(Check only 2 Me	dical Exami	ner: On the basis and manner s	of exeminat	ion and/o	or Invest	tigation, in my o	plnion, death occu	rred at the tima, d	ate and place,	and due to	the ceuse(s)
	Within To the Comp	Ž	29b. Signature end title of	entifiar)_		A		29c. Licens	e number		9d. Date signe		
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			30. Name and address of p	sop who co	empleted cause of					מה בוו			1)	2.822
			31. Date filed (Month Day	Veer	WM),	BIII		11/1		ILIP DR	OLIVE	7, U	ND	1003
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	•							Jana	200					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month **Physician** 1:49+m William APRIL 1997 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. Obunty of Deeth Examiner Prince George's Hospital Center If Under 1 Year Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
Nov. 15, 1 Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Country) Virginia Funerai 214-32-8960 1⊠M 2□ F Yrs. 66 1930 Director Usuel Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Maryland Prince George's Director Hyattsville 1 to Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whei Country? 6 death with 5101 Emerson Street 238 20781 U.S.A. Funeral Hems ? 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Reca - American Indian, Black, White, etc. 11. Maritel Stetus Pages 1 and 2 should be filed within 72 hours after nent of Health end Mental Hygiene. 1 Never Married 2 ☐ Married 6 21215-0020 If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 Widowed 4 Divorced White "natural". Be Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decadent's Usuel Occupetion (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working 7.27 is marked other than "n traumatic event Elementery/Secondery (0-12) College (1-4or 5+) Clerk Automobile Dealership Baltimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) John Van Dyke 2 Ella Mae Sheets 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) nt of Health e Shirley L. Hoffman - Cousin 5326 Crittenden Street, Hyattsville, Maryland 20781 20b. Plece of Disposition (Neme of cometery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ₺ Buriel 2 □ Cremetion 3 □ Removel from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 4/26/97 Brentwood, Maryland Fort Lincoln Cemetery 21. Signifilate of Funeral Service License 22. Name end Address of Fecility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, ock, or heart feilure. List only one cause on eech line. Approximete interval Between **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed the buriel-trensit Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Lest Box 68760. Physician/Medicai use esu P.O. I ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ director, page 2 should be Completed 24b. Were autopsy findings evellable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? certificete 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Inpatient 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA After this filled in by the funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending investigetion death. 1 Yes 2 No 2 Accident or Attend after death Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homlcide Hospital 24 hours a • Funeral Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted. 29a, Certifier To the Hosp within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Year) 30. Nems and eddress of person who completed cause of the

State Registrar

31. Dete filed (Month, Dey, Year) APR 28 1997 32 Registrar's Signeture

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Holmes Frid

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month APRIL 10:25 A.M. JAKA Μ. DANNER 1997 27 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BURNIC ARUNDEL GleN ANNE ARUNDEL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Months Days Hours Min. May 2, 1917 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign Country) New York 1□M 2⊠F New 077 07 4131 79 Usuai Rasidanca of Decadant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 HNo Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zin Coda 10g. Citizan of What Country? 21114 United States 1765 Crofton Parkway Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Dacedant Evar in U,S. Armed Forcas? 11. Marital Status 14. Race - Amaricen Indian, Black, Whita, atc. 1 Navar Married 2 Married 1 Yas XX No If Yas, Giva Yaar or Datas: 1 Yas 2 XX Spacify: Specify: 3 Vidowed 4 □ Divorced White 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Sales Clerk Retail 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Alfred A. Denton Agnes Bessen 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) 1816 Foxdale Court Crofton Maryland 21114 Lynn Dyke Daughter 20b. Place of Disposition (Nama of camatary, cramatory or other place) April 29, P997 20a, Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 文文文ramation 3 ☐ Ramoval from State Metropolitan Crematory Alexandria Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715 23a. Part1. Enter the disease, or complications the ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarvai Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) myo cardial inforction Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaase or Injury Dua to (or as a consequence of) that initiated avants rasulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasuiting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Sevsis 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No 28. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Exemples must be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter deeth v Deperment of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "natural, or items 23s any injury or other traumatic event, tra Med cal Examinat mast.) and others.

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records.

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/Medical

Director

Funeral

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Physician/Medical 2 Completed Be P Certification:

Examiner

requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours eiter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

State Registrar

Medical

(Check only one)

25. Was cesa rafarrad to medical axaminar? 1 Yas 2 No 27. Mannar of Death 28a. Data of injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 5 Panding invastigation 1 DNatural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarminad 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 | Homleida 29a. Cartifian

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifler 29c. Licansa number

23624

29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated ceusa of death (itam 23a) (Type, Print) 1600

Highway SN Clen Burnie Md. 21061

B. Mand ol Wa | 31. Data filad (Month, Day, Year) APR 29

A Affic Victoria (Carlo de la Carlo de la

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0(4 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death 3. Time of Death **Physician** Month 10:42A 25 Herman /Medical 4a. Facility Name (If not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Death Examiner Spring Holy Con 5. Social Security Number Cross Hospila Montojomery dver If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Dey, Year) 1 X M 2 ☐ F Deys Yrs. Director 246-40-6797 Nov 26, 1921 North Carolina Usual Residence of Decadent 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f show Director fX☐ Yes 2☐ No Wheaton Maryland | Montgomery 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 901 Arcola Road 20902 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iter any Injury or other traumetic event, tre Medical Examine Dobes. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Completed by Specify: Black 3 XWidowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Farmer Farming 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surneme) Be Herman Dupree, Sr. Christine Morgan 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Barbara A. Fisher /Daughter 103 Rosemary Ct., Dudley, N.C. 28333 20b. Place of Disposition (Name of cometery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hamilton Funeral Home 4/30/97 Goldsboro, N.Carolina 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike, Forestville, Md. 23e. Part 1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel Urose disease or condition resulting in death) **Examiner** to (or as e consequence of) Physician/Medical Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): the Due to (or as a consequenca of) for use as Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Whitenown à Completed 24a. Was en eutopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of death? 2 res 1 Yes 2ALAK 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 □ Impatient 2 □ ER/Outpatient 3 □ DOA 27. Manner of Death Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, signed by t certificate has or Attending Physician: After this

the Maryland

death

Baltimore, Maryland 21215-0020

To the Hospital Within 24 hours To the Funeral C

State

Registrar

A after deau.

And Director: After bu.

In by the funeral di Certification: Medicai

29a. Certifier (Check only one)

2 Accident

3 Sulcide

4 Homicide

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) and manner as steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number

Wheaton

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Dey, Year)

Location (Street end Number or Rural Route Number, City or Town, Stete)

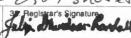
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

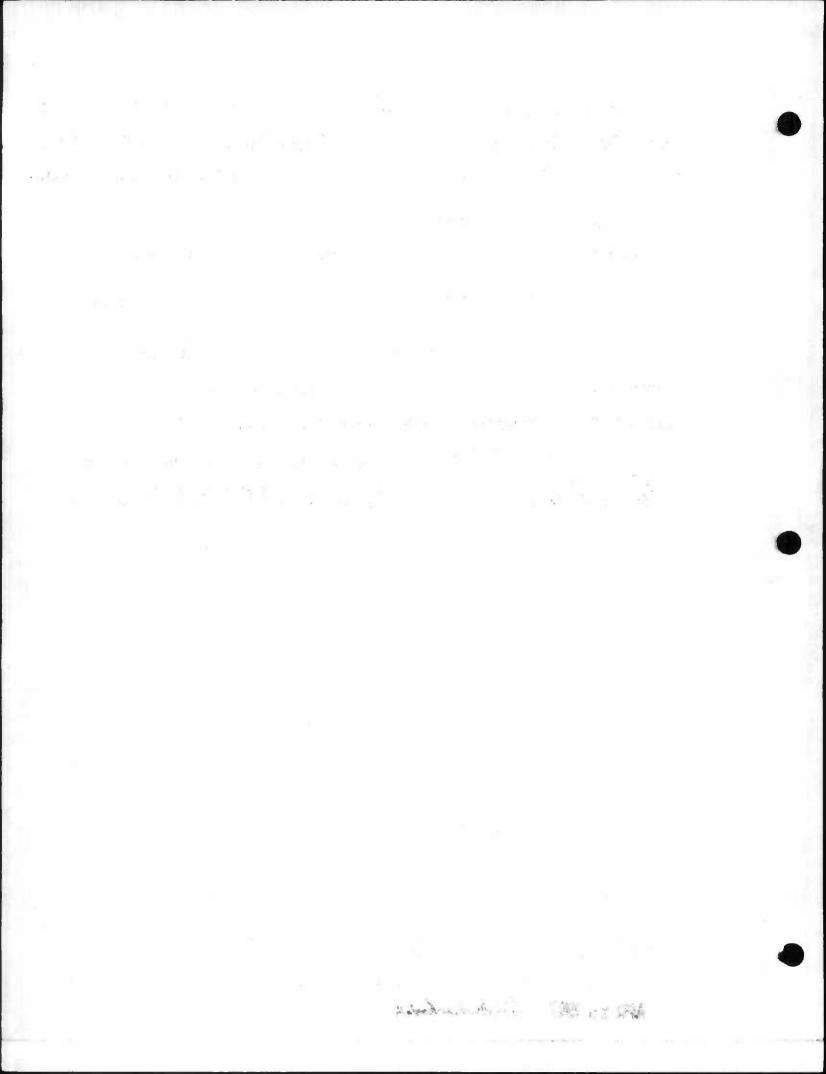
2309 Shorefield Rd

31. Date filed (Month, Dey, Year)

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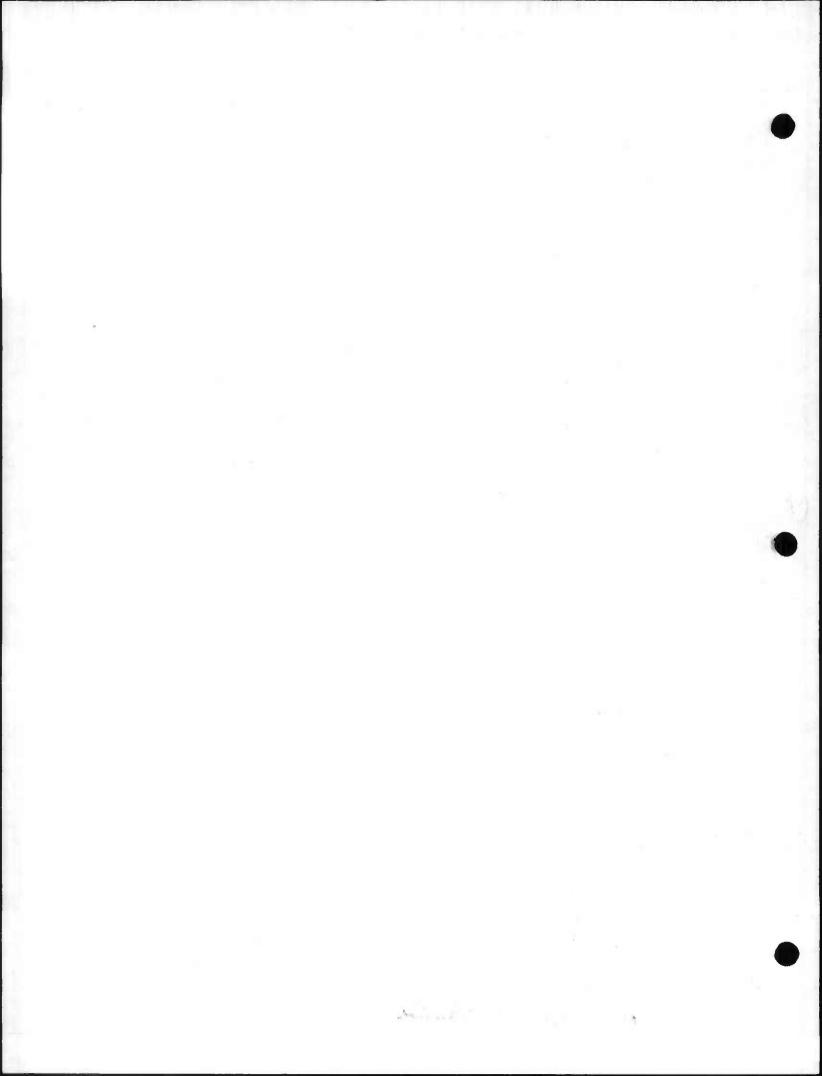




State of Maryland / Department of Health and Mental Hygiene

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	ylend		10a. Stata 10b. County		10c. City, Tow	n or Location				10	d. Inside City Limits
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	23e or 28	Funeral Director	10e. Street end Number 249- V Street	N.W.		10f. Zip Code 2	0001		10g. Citizen of Unit		•
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Balt	permit. Page Department of Important: If eny Injury or once.		21. Signature of Funeral Service Lice	ensee	100.00	22. Nama and Addre	ess of Facility S	nead Mo	rtuary	Ser	
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no	Atter fune	ig Ig	27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, De	y Yeer) 28b. 1	ime of 28c. Injury Woo	ryat rk? Yes 2 □ No	28d. Describe i	now injury occur	red	
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	To the To the comple	Me	29b. Signature and little of certifier	c. License number 29		29d. Date signe	d (Month, D	ay, Year)			
	(3)		30. Name and address of person who	1 . 1		Tyme Print)					
			Jee Jone Th 31. Dete filed (Month, Day, Year)		er hn	5530 1	NISCONSI	n. Ave	Chemy	hose	Mn 208/3
	Sta Registr		APR 3 0 199	7	ar's Signature	dall					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month MAY 04, JAMES DAVIS 1997 0600 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert 7. Age (In yrs. last birthdey) if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) March 24,1934 North Carolina Birthplace (State or Foreign
Country) 1X M 2 F 63 Months Deys Hours 238-46-8954 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Maryland Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8342 Pushaw Station Road 20736 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1X Yes 2 No 1952— If Yes, Give Year or Dates: 1956 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Federal Government Facilities Manager 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James S. Davis Frances Harvey 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Davis/Wife 8342 Pushaw Station Road Owings, MD 20736 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) White Rock Baptist Cem. 5/10/97 Hollister, NC 22. Name and Address of Facility Sewell Funeral Home 21. Signature of Funeral Servica Licensee 1451 Dares Beach Rd. Prince Frederick, MD20678 20 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervai Between Onset and Deeth immediete Cause (Final disease or condition resulting in death) stage van Hodgkin's lynyshoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): Part ii. Other significant conditions contributing to death but not resulting In the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4CHiknown cural effection, pulmougnetestases, 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? coronary ortery discouse 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 2 □ ER/Outpetient 3 □ DOA

Physician /Medical **Examiner**

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Division of Vital or Attending Physician: **Physician**

/Medical

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filed within 72 hours efter Hygiene. other than "natural", or ite

permit. Pages 1 end 2 should be filk Department of Health end Mental Hy Important: If item 27 is marked oth any injury or other traumetic avent

Baltimore, Maryland 21215-0020

Physician/Medical þ Completed Be

1 Yes 2 No 27. Manner of Death

5 Pending

6 Could not be determined

28e. Date of Injury (Month, Day Year) investigation

28b Time of

28c. injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e, Certifier (Check only one)

1 Naturai

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Bertifier

32. Registrar's Signature

28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 36255 29d. Date signed (Month, Day, Year)

30. Name end eddfess of person who completed cause of death (item 23a) (Type, Print)

120 Hogse Tel Frederick MB 20678

State Registrar

31. Date filed (Month, Day, Year) Jelin Davidson-Rardall

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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Ler PAI 4a. Facility Neme (Ithnot institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MERK ANO RINCO NOX if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) AUG. 28, 1927 CROSS, SC 5. Sociel Security Number 6 Sev 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Deys Hours 1 XM 2 □ F 249-30-3889 69 Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No MARYLAND PRINCE GEORGE'S BRANDYWINE 10e. Street end Numbe 10f. Zip Code 10g, Citizen of What Country? 8403 BELDING COURT 20613 USA 12. Was Decedent Ever in U,S. Armed Forces? 1∑ Yes 2 □ No ARMY If Yes, Give 11. Marital Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Vear or Dates: 1946-1956 BLACK Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STEAM SHIP TRADE (PVT.) LONG SHOREMAN 8th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) JAMES EADIE GUSSIE WASHINGTON 19a. informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) HOWARD EADIE/ SON 8403 BELDING CT. BRANDYWINE, MARYLAND 20613 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State XBunal 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 4-25-97 CLINTON, MARYLAND FOREST HILLS CEMETERY 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND RD. SUITLAND, MD 20746 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final 324/4 ASPIRATION disease or condition resulting in death) INSUFFICIENCY Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Vasculer Acedemic Cerchon Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Is 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No DODM DVT 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 2 NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work?

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end manner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner stated.

29c. License number

DU6478

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Dey, Year)

4.22.97

clinton. MD20735

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

rail, or items 23a or 28a-f show Examiner must be notified at

"natural", or

olth end Mental Hygiene. 27 Is marked other than "I r traumatic event, me Med

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permit. Page Depertment of Important: If any Injury or

Director

Funeral

Completed by

Be

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the Maryland

death

filed within 72 hours after

21215-0020

Baltimore, Maryland

P.O. Box 68760.

Records,

the buriel-tran for use es signed by page 2 should peed funeral After

Physician/Medicai ð Completed Be 10 Certification:

The law requires that the death certificate be executed this certificate Attanding Physician: death Director: A

Medicai State Registrar

Division of Vital 0 Hospital C To the Hospital within 24 hours e To the Funeral C

31. Date filed (Month, Dey, Year) MAY 01

5 Pending investigation

6 Could not be

7501 Symatts Rel \$1302. Patel MD 32. Registrer's Signeture

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Suresh A.

1 Naturei

2 Accident 3 Sulcide

4 Homleide

(Check only one)

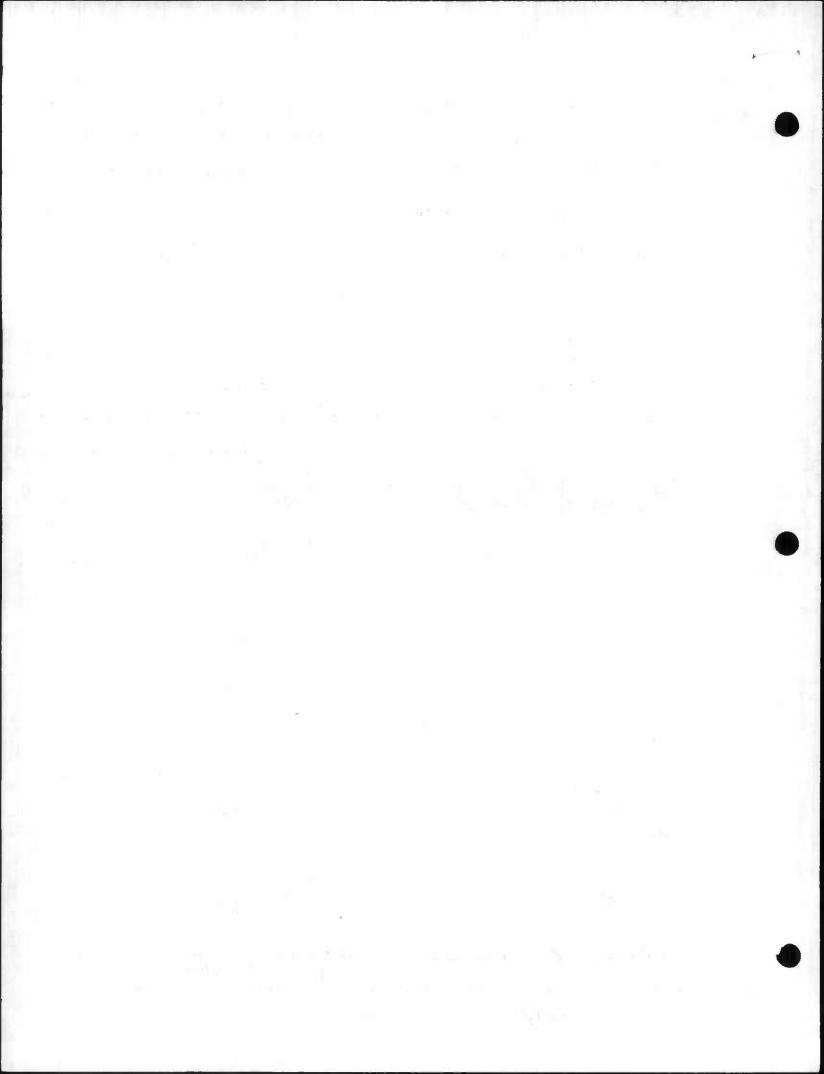
29b. Slaneture end title of certifier

29a. Certifler

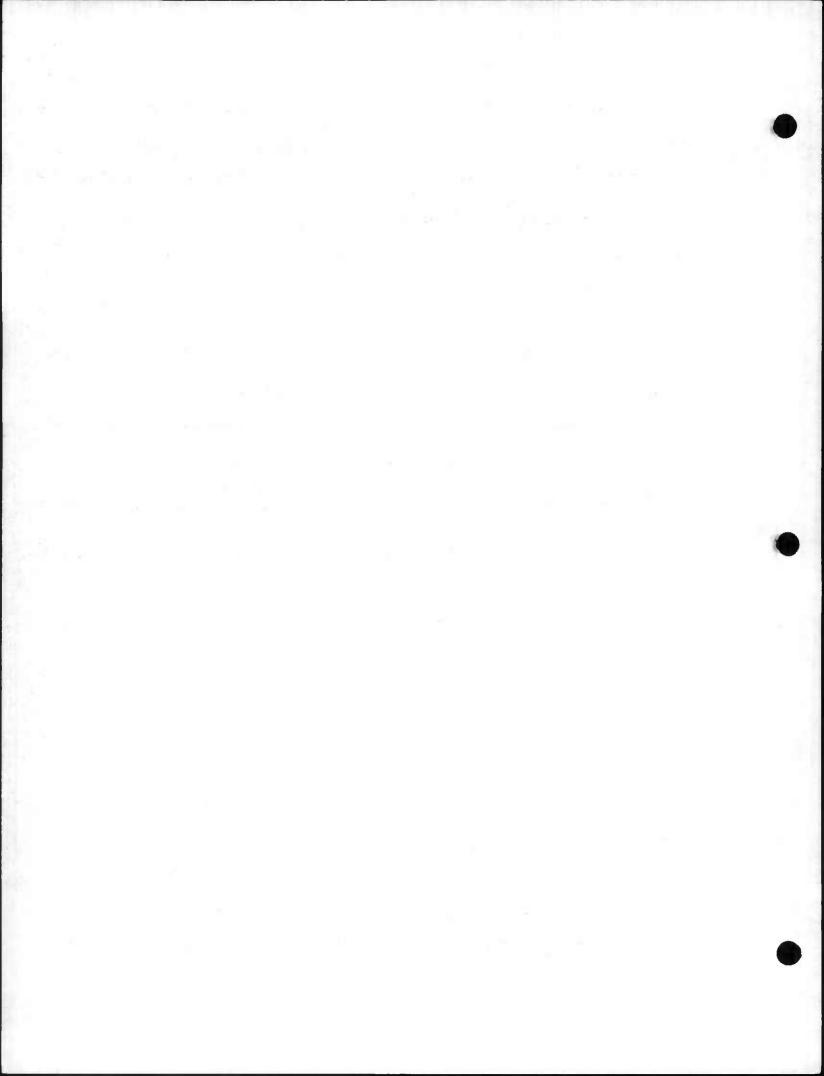
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Arrended #	8,	20b, 5/1/97, JW, Mont	. Cty.	Maryla	nd / Depa <i>Cei</i>			lealth a Death	nd Ment		jiene eg. No.	97	147
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Examin	er	4a. Facility Neme (If not institution, git 13304 Brackle		oer)				Silve	n, or Location		4c. County MON	of Death TGOME	ERY
Funeral Director		218-18-1387	6ex 7. I□ M 2⊋F	Age (In yrs	. last birthday) Yrs.	If Und Month	er 1 Year S Deys	Hours	Min. (N	te of Birth fonth, Day,	1912	9. Birthple Country Mar	yland
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ath with the	Funeral Director	10e. Street and Number 13304 Brackle	y Road	.,		10f. 2	209	04		1	0g. Citizen of V		n
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ealth and m 27 is m		19a. Informant's Name/Relationship (Marjorie Will			ter)	1330)4 B:				City or Town, ilver		
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To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier				25	O 2				ed. Dete signed		
		30. Name and address of person who		f daath (iter		,		RANDA	Uston	ON, NOW	1	21133	
State Registra	•	31. Date filed (Month, Dey, Year)	32. Regi	strer's Signa		01	0 60	111	RA			41133	•

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П	Funeral		5. Sociel Securit			7. Aga (In yrs.	lest birthday) If Undar Months		If Under	24 Hrs. Min.	8. Deta of B (Month, D			rthplece (Stete or Foreign country)
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Baltimore, Maryland 21215-0020			21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility											xandri	a,_VA
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	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by tha		29e. Certifiar	1 Certifying Pr	ysician: To the	best of my kno	wledga, deet	h occurred a	t the tir	me, deta en	d plece,	end due to the	ceuse(s) a	nd menner e	s stetad.
	he He in 24 he Fu	one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurrence on the basis of examinetion end/or investigation, in my opinion, deeth occurrence on the basis of examinetion end/or investigation, in my opinion, deeth occurrence on the basis of examinetion end/or investigation, in my opinion, deeth occurrence on the basis of examinetion end/or investigation, in my opinion, deeth occurrence on the basis of examinetion end/or investigation, in my opinion, deeth occurrence on the basis of examinetion end/or investigation, in my opinion, deeth occurrence on the basis of examinetion end/or investigation, in my opinion, deeth occurrence on the basis of examinetion end/or investigation.							th occurr	ed at the time	, dete end p	lace, and du	e to the cause(s)		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended #7, 4/29/97, JW, Mont. Cty. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth APRIL 27, 1997 **Physician** 3:45AM **ANDREW** FOLDES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 6. Sex 1 M 2 F If Under 1 Year if Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Dey. Year) JULY 1, 1909 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** Deys Hours HUNGARY 052-36-7876 87 88 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No BROWARD FL W. PALM BEACH 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 WINDSOR, NORTH (CENTURY VILLAGE) 33417-2453 USA deeth 12. Was Decedent Ever in U,S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Pages 1 end 2 should be filed within 72 hours efter nent of Health and Mental Hygiene. 1 Never Married 2 Married 21215-0020 "natural", or 1 Yes 2 No Specify: by Specify 3 Widowed 4 Divorced WWII WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ulth and Mental Hygiene. 27 is merked other than 'r r traumatic event, tre Me College (1-4or 5+) 5+ Elementary/Secondary (0-12) DOCTOR ALLERGIST Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be EUGENE FOLDES STRASSER 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informanf's Name/Relationship (Type, Print) nt of Health and If Item 27 is m or other traun MICHELLE PEYSER / DAUGHTER 7017 ENDICOTT CT., BETHESDA, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERSIDE CEMETERY 4/29 SADDLE BROOK, NJ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Almons DANIEL SIMONS 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** /Medical Immediete Cause (Finel GLIOBLASTOMA MULTIFORME OF BRAIN disease or condition resulting in death) **Examiner** Examiner The law requires that the deeth certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical Due to (or as a consequence of): 88 signed by the end to be detached for P.O. 1 Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2000 3 Probably 4 Unknown Records, b 24b. Were autopsy findings evailable prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 1 Yes 2 No of Vital or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/No Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this the funeral 27. Manner of Death Dete of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After Division 5 Pending Investigation Injury 1 Yes within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifler 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only the 29b. Signature agd 29d. Date signed (Month, Dey, Year) 29c. License number D18084 5 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print) 6121 MONTROSE RO, KOCKVILLES MD 20852 ATEL M-D 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State ilia Davidson-Randall APR 2 9 1997 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

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	Physic /Medi		JOHN ALBERT FAC	GAN					APRIL	28	1997	0740
2	Exami		4e. Fecility Neme (If not institution, gire	e street and numi	ber)			4b. City, Town, or I	ocation of Deetl	4c. County	of Deeth	- 16
			Holy Cross Hos	oital				Silver Sp:	ring	Mont	gomer	·V
п	Funeral		5. Sociel Security Number 6.	Sex 7	. Age (In yrs. ie	st birthday)	If Under 1 Yes		8. Dete of Bir (Month, De	th	9. Birthpl	lace (Stete or Foreig
-	Director		579-18-0699	1₩ 2□F		79 Yrs.	,		June 21			ngton, D. C
	pu k		Usuel Residence of Decedent 10a. Stete 10b. County		10o City	Town or Loc	ntion					
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	Sa-f	Director	Maryland Montgon	nery	Kens	singto						1 ☐ Yes 2½ No
	death with the Maryland ms 23a or 28a-f show		10e. Street end Number				10f. Zip Code	•		10g. Citizen of	Whet Count	iry?
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5		Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Decede	int's Usuel Occ ind of work dor	upation ne during most of work ired)	king	16b. Kind of B	usiness/ind	ustry
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2	d Me nark natio	6	George Washingto			406 11-11-	4.44 701	Beulah N				0.11
Maryland 21215-0020	Ta La			rype, Pnnt)		19b. Melling	Address (Stre	et end Number or Ru	rei Houte Numb	er, City or Town	, State, Zip	Code)
	s 1 and f Heelth frem 27 other tr		Gladys V. Fagan 20e. Method of Disposition		20h Ple	3010]	Ferndal	e Street	Kensing	ton, Mar	yland	_20895
õ	H H to		tx Buriel 2 □ Cremetion 3 □	Removei from St	tete Cer	metery, crem	tion (Neme of story or other p	riece)	Dete	20c. Location	- City or Tov	wn, Stete
altimore,	tant:		4 □ Donetion 5 □ Other (Special	2010-11	Stor			Gardens !	5/01/97	Manassa	s,Vir	ginia
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ii.			23a. Part). Enter the disease, of com- shock, or heart failure. List only	plications that cau	used the deeth.	Do not enta	the mode of d	ylng, such es cardiec	or respiretory a	rrest,	1	Approximete
	Physician					_						Onset end Deeth
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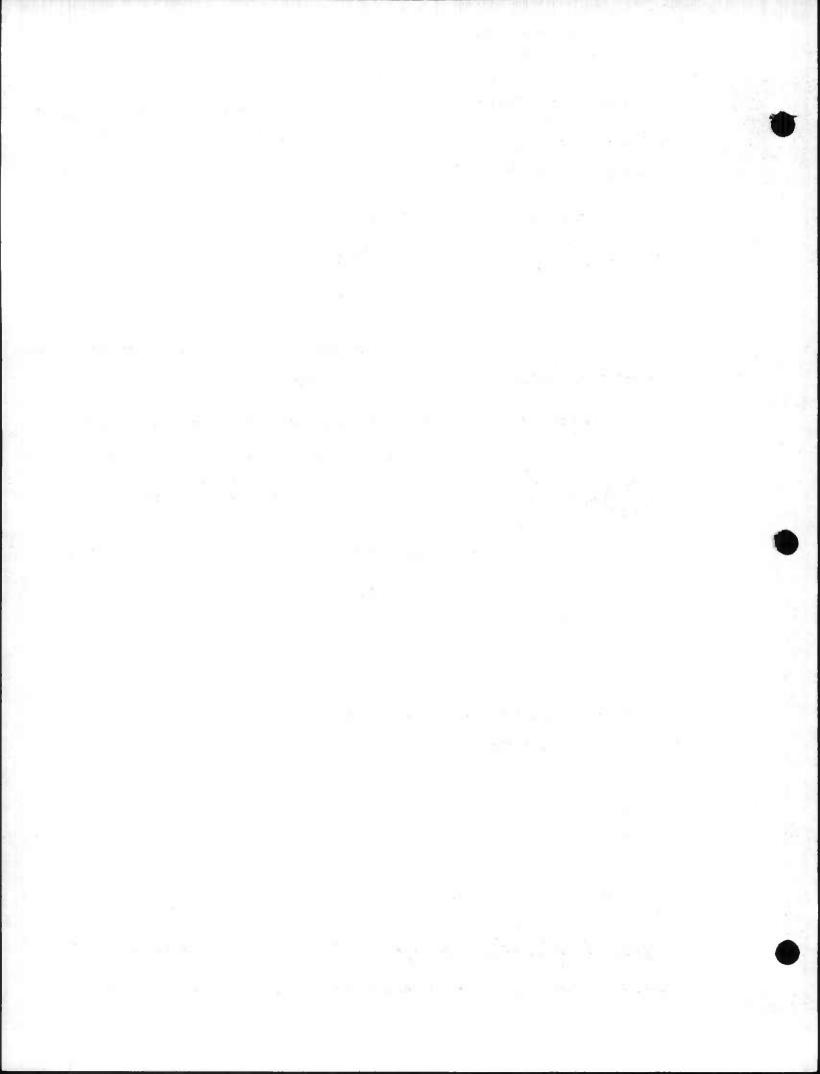
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Registrar

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NAME OF THE PARTY

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and and		Usuel Residence o 10e. State	10b. County		10c. City,	Town or Loc	ation				1	0d. Inside City Lin
Mery	tor	MD	Montgome	ery	Che	vy Cha	se					Yes 2
h the	Director	10e. Street end Nu	mber				10f. Zip Code			10g. Citizen of	Whet Cour	ntry?
230 c	al D	5503 Cen	iter St.				20815			U.S.A		
permit. Peges 1 end 2 should be filed within 72 hours efter death with the Meryland Deperment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28a-f ehow eny Injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Maritel Stetus 1 ☐ Never Marr 3 ☐ Widowed	led 2 Merried	12. Was Decedent Armed Forces? 1 Yes 20 If Yes, Give Yeer or Detes:		lf '	es Decedent of I Yes, specify Cub	Hispanic Origin? (Seen, Mexicen, Puer Specify:	Specify Yes or N to Rican, etc.)	0- 14. Re Ble	ce - Americ ck, White,	etc.
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After After funer	lon	27. Manner of Deat 1 Neturel	n 5 Pending investigation	28e. Dete of Inju (Month, Da)	Y Year)	28b. Time of Injury	28c. Inju Wo	ryat rk? Yes 2 □ No	28d. Describe	how Injury occu	red	
or Attending Physician: after death. Director: After this certific in by the funeral director,	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined		ury - At hon c. (Specify)	ne, ferm, stree		7100 2 2 110		(Streat and Num wn, Stata)	ber or Rura	I Route Number,
To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)	1反 Certifying Phy 2급 Medicat Exam	ysician: To the best of ilner: On the basis of end menner sta	exeminetic	ledge, deeth o on end/or inve	occurred et the ti stigetion, in my o	me, date and place opinion, deeth occ	e, end due to the urred et the time,	ceuse(s) end m , dete end placa,	anner as st	ated. the cause(s)
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				M.D. 1040			*	#606 W	ancinat	on Ma	0005	
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State of Maryland / Department of Health and Mental Hygiene 97

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						Certifi	icate of	f Death	F	Reg. No.	-	14131
į	Physic		Decedant's Nama (First, Middla, Last,	Dorothy	R. F	rench			2. Data of Dea Month May	ath Day	Year 997	3. Time of Death
	/Medi Examii		4a. Facility Nama (If not institution, giva Laurelwood Nursia	HILLIAN CO.				4b. City, Town, or Elkton		-	of Death	
0	Funeral Director		5. Social Security Number 6. Sat 214-12-0936 Usual Rasidance of Decedent	7. Ag	e (In yrs. Ia 82	Mo	Under 1 Yee onths Days		_ U. DOIG OF BITT	Year) , 1915	Cou	place (Stata or Foreign ntry) ginia
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	h with the 23a or 284 list be not	al Director	10e. Street end Number 505 Big Elk Chape	el Road		1	0f. Zip Coda 21921			U.S.A.		ntry?
020	be filed within 72 hours after deeth with the Maryland nat Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Merital Status 1 □ Nevar Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedant Armed Forcas? 1 Yes 2 11 If Yas, Giva Yaer or Datas:		If Ye		Hispanic Origin? (Stban, Maxican, Puerto Specify:	pecify Yes or No- o Rican, atc.)		14. Race - American Indien, Black, White, atc. Specify: White	
21215-0020	vithin ne.	Completed	15. Decedent's Edu (Specify only highast grade Elementary/Secondery (0-12)	cation a co <i>mplated)</i> Collega (1-4or 5	i+)	life. DO f	s Usuel Occi l of work don VOT usa retir maker	a during most of wor	rking	16b. Kind of B	usinass/in	dustry
Maryland	ahould be filed v nd Mental Hygie i marked other t umatic evant, th	To Be	17. Fathar's Name (First, Middla, Last) Robert Tes	terman				18. Mothar's Nar	na (First, Middla, Mary Go		na)	
	ta and		19a. Informant's Neme/Ralationship (Ty Albert L. Caldwe		100/15	505 B	ig Elk	t Chapel F	Road - Ell	cton, M	D 21	1921
altimore,	permit. Pages 1 end 2 Department of Heelth a Important: If itsm 27 is any injury or other tra once.		20a. Mathod of Disposition 1 ☑ Burial 2 □ Cramation 3 □ R 4 □ Donation 5 □ Othar (Specify)		Cei	natary, cramato	ry or othar pi	Cemetery	5-6 1997	Owing:		own, Stata
Bal	Departiment Important		21. Signatura of Funeral Sarvice License	Hicko				rass of Facility e for Fun ockton St			ID 21	921-5521
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s, P.O. B	requires that the death certificate be executed seen signed by the attending physician and hould be deteched for use as the burlat-transit	by Physician	Part II. Other significant conditions con Coronau Anto			ting in tha undar	lying causa (givan in Part I.				o the cause of death?
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of <	0 0	P	examinar? 1 Yes 2 No	lospital:			DOA	other: 4 Wursing H	loma 5 ☐ Rasid	lance 8 DOth		fy)
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III WEST MIGH STreet, ELKTON, MD

State Registrar MONTE

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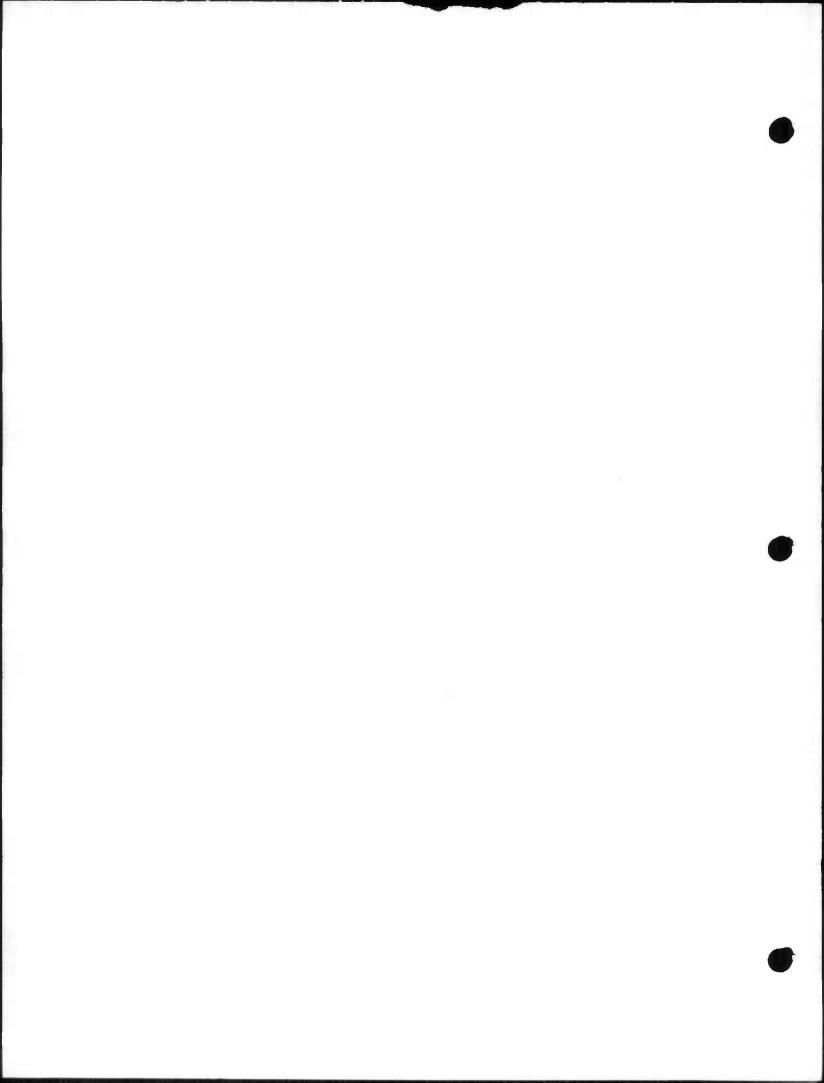
1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 1997 MARION RUTH MAY FEESER 8:45AM м 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last hirthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS 1 M 2 XF 83 220-34-6842 APRIL 914 MARYLAND Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR WESTMINSTER NURSING AND CONVALESCENT CENTER WESTMINSTER CARROLL RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY TANEYTOWN MARYLAND CARROLL 1 YES 2 NO 10a STREET AND NUMBER FUNERAL 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 5190 FEESER ROAD WEST 21787 USA 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. tt yes, spectfy Cuban, Maxican, Puerto Rican, atc.) 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TES 2 NO Specify. 3 Wildowed 4 Olvorced ΒY as the CAUCASIAN COMPLETED 15. DECEDENT'S EOUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Spe 10 Elementary/Secondary (0-12) College (1-4 or 5+) 7th DAIRY FARMER detached AGRICULTURAL once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 90 3 CLARENCE ORVILLE SNYDER FLLEN CATHERINE HOUCK BE 5 should notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY A. WILSON, TANEYTOWN, MARYLAND NIECE 23 FAIRVIEW AVENUE 21787 page be METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of 20c. LOCATION - City or Town, State DATE 1 X Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) must director, TRINITY LUTHERAN CEMETERY 5/6/97 TANEYTOWN MARYLAND examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Kevin 136 EAST BALTIMORE STREET SKILES FUNERAL HOME TANEYTOWN, MARYLAND 21787 e medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart feiture. Liet only one cause on each line. interval Batween 70 IMMEDIATE CAUSE (Finel Onset and Death disease or condition the Metastatic Lung and completely f burial, crematio 2 m s resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediata cause. Enter UNDERLYING the attending physician Mental Hygiene prior to CAUSE (Disease or injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 70 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? Alzheimers Demanti. any 1 TES 2 NO Dinbalas shows a Me11: 1-1 YES 2 NO Deen . DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate I the State I, or Item HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 YES 2 NO 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, With W 5 Pending investigation 1 Natural 1 YES 2 NO BY After death 2 Accident 26a. PLACE OF INJURY — At home, ferm, street, tectory, office building, stc. (Specify) 3 Suicide 261, LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 ETED 6 Could not be DIRECTOR: Journ after of item 28 Is 4 Homicide determined 29a. CERTIFIER

(Charle only)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated COMPL FUNERAL F IMPORTANT: II 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, 王분 man 032883 Holub 7 28 9 30. NAME AND AQORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Robert 6. Mali 114 4150851 MJ 31. DATE FILEO (Month, Day, Year) 32 REGISTRAR'S SIGNATURE OHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



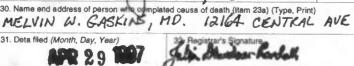


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Deeth **Physician** MINNIE M. FINCH 7:52 7M APRIL 24 /Medical 4e. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daeth
TAKOMA PARK 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL MONTGOMERY If Undar 1 Yeer If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) **Funeral** Birthplace (Steta or Foreign Country) 1□M 2XF Yrs. Director 250-62-5977 60 AUG. 16, 1936 SOUTH CAROLINA Usual Rasidance of Decedant the Maryland 10a Stata 10b Count 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at MD. PRINCE GEORGES HYATTSVILLE Director 1 Yas 2 No 10e. Street and Number 10f. Zlp Code 10g. Citizan of Whet Country? ŏ Items 23a 20782 Funeral UNTTED STATES AMERICA
o- 14. Race - American Indian,
Black, Whita, atc. 1009 CHILLUM RD. APT 313 12. Was Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispenic Origin? (Spacify Yes or No-lf Yas, specify Cuben, Maxican, Puerto Rican, atc.) Pages 1 and 2 should be filled within 72 hours after of health and Mertal Hygiene.
The filem 27 is marked other than "natural", or flee in yor other thaumafte event, the Mexical Example. 1 Navar Marriad 2 Married 1 ☐ Yas 2 ☑ No If Yas, Give Yeer or Datas: Baltimore, Maryland 21215-0020 1 Yas 2 No þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 6 YRS. SCHOOL SYSTEM D.C. PUBLIC SCHOOL 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maldan Surnama) Be KENNY MCFADDEN LENA MCFADDEN 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Steta, Zip Coda) 1009 CHILLUM RD. APT. 313 SHELLY FINCH HYATTSVILLE, MD. 20782 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 Burial 2 Crametion 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) FT. LINCOLN CEMETERY 4/29/97 BRENTWOOD, MD. 21. Signature of Funeral Service License 22. Nama and Addrass of Facility JOHNSON & JENKINS INC. 716 KENNEDY ST. N.W. W.D.C.. 23a. Pert1. Enter the disease, or complications that baused the court. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Deeth **Physician** /Medical immediata Cause (Final RECURRENT BREAST CANCER 6 MONTHS disaasa or condition rasulting in death) Examiner Examiner HONTHS LIVER METASTASIS The law requires that the death certificate be executed use es the burial-transit Sequantielly list conditions, if any, laading to Immadiata ceusa. Entar Underlying Causa (Disaase or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760, 6 HONTHS BONE METASTASIS Physician/Medical CARDIAC ARREST Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by Completed 24a. Was an eutopsy performed? 24b. Wara autopsy findings evailable prior to completion of cause of death? certificate has 2 No 1 Yas 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarred to medical 26. Pieca of Daath (Check only one) axaminer? 1 Yes 2 No Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 1 ☐ Inpatiant 2 SER/Outpatient 3 ☐ DOA Certification: To this 28a. Data of fnjury (Month, Day Year) 27. Mangar of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After 5 Panding Investigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicida To the Hospital or within 24 hours of To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledga, daath occurred at tha time, dete and place, and due to the causa(s) end mennar as stated.
2 Medical Examiner: On the best of axamination end/or invastigetion, in my opinion, daath occurred at the time, data and place, and due to the causa(s) and mannar stated. Medical 29a, Certifier 29b. Signature and titla of certifiar 29c. Licansa number 29d. Data signad (Month, Day, Year)

31. Deta filed (Month, Day, Year)

30. Name end address of person w





220 MITCHELLVILLE, MD 20721

Registrar

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Please Type of Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death BERNICE PRII City, Town, or Location of Daath 4a. Facility Neme (If not institution, giva street end numbar) 4c. County of Death outhern istor ARENARIO If Under 1 Yaar If Undar 24 Hrs. Months Deys Hours Min. 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yaar) 9. Birthplaca (Steta of Foreign Country) Deys 1 M 2 TyF 240-72-3917 December 22. South Carolina Usuai Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Prince George's Camp Springs 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 5000 Brinkley Road 20748 United States 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Maxican, Puarto Ricen, atc.) 12. Was Decadant Evar in U,S. Armed Forcas? 14. Rece - Amaricen Indian. Black, Whita, atc. 1 Nevar Married 2 Marriad 1 ☐ Yas 2 ☑ No If Yas, Giva X Year or Datas: 1 ☐ Yas 2 ☐ No Spacify: 3 ♥ Widowed 4 Divorced Black 15. Dacedent's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) Farm Worker Private 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Elark Bradley Janice Isaac 19a. Intorment's Nama/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)

Physician /Medicai **Examiner**

Physician/Medical Examiner

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Certification:

Medical

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page 2

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If or Attend after death Director: / d in by the f

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnital Sofice.

Physician

/Medical

Examiner

10a. Stata

Maryland

6

20a. Mathod of Disposition

Helen Wilson/Daughter

21. Signature of Funarel Sarvice Licenses

1 ☐ Buriai 2 ☐ Crametion 3 ☐ Ramovei from Stata 4 ☐ Donetion 5 ☐ Othar (Spacify)

, Funeral

Director

28a-f show

6

"natural", or items 23a

The Medical Examiner must be notified at

Director

by Funeral

Completed

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0020

Sequantielly list conditions, if any, laading to immadiata ceusa. Entar Undarlying Causa (Disaesa or Injury that initieted avants rasulting in daath) Last

Immediata Causa (Finel

disaesa or condition rasulting in death)

Due to (or as a consequence ot): Dua to (or es a consequence ot) Dua to (or as e consequance of):

5000 Brinkley Road, Camp Springs, MD

4001 Benning Road, N.E. Wash., D.C.

Date

Stewart Funeral Home

14/28/97

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.

Amenne Orbleeding 23b. Dld tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nohknown

24a. Was en autopsy performed?

24b. Wara autopsy tindings avellable prior to complation of causa of death?

20748

20019

Landover, MD

20c. Location - City or Town, Stata

1 Yas 2 No 26. Placa of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case retarred to medicat exeminar? 1 Yas 2 No	
27. Menner of Death 1 Netural 5 ☐ Panding	1

5 Panding Invastigation

28a. Dete of injury (Month, Day Year)

1 Minpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

20b. Piace of Disposition (Nama of cematary, cramatory or other plece)

Entar tha disaasa, or complications that ceused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one cause on each line.

Harmony Memorial Park

22. Nama and Addrass of Facility

Carcinome of stomach with mETS

Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify)

1 Yas 2 No

28d. Describe how Injury occurred

6 Could not be datarminad 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 - Homicida 1 Cartifying Physician: To tha best of my knowledge, daath occurred et tha tima, data end piece, end dua to tha causa(s) and mannar es steted.

2 Medical Examinar: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at the time, deta and place, and dua to tha ceusa(s) and mennar stated. 29a. Certifier

28f. Location (Streat and Number or Rurel Routa Number, City or Town, Stata)

(Check only one) 29b. Signatura and titia of certifian

2 Accidant

3 Suicide

29c. License number D46478 29d. Date signed (Month, Dey, Year)

30. Nama and eddress of person who complated ceuse of daath (Itam 23e) (Type, Print) 7501 Surratts Rd # 302. Clinton mD20735 patel mo Suresh A.

31. Data tiled (Month, Dey, Yaar)

32. Registrar's Signatura

State Registrar

APR 29 1997



Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed

Amending Physician:

To the Hospital within 24 hours a To the Funeral D completely filled

28 23 28A

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Physic	lan	Decedant's Nama (F	First, Middle, Las	st)						2. Dete of Dea Month	ath Day	Yaar	3. Time f th
/Med		GILBERT								APRIL		1997	8:42 6
Exami	ner	4a. Facility Nama (If no						4b.	City, Town, or Lo	ocation of Deeth	4c. Count	y of Death	
	اللبور	Prince G							Cheverly			ce Geo	
Funeral Director		5. Social Sacurity Number 578-24-97	59 ¹	ax ÖM 2□F		last birthday) Yrs.	If Under 1 Months D		If Undar 24 Hrs. Hours Min.	8. Data of Birt (Month, Da Feb. 15	h y, Year) ,1917		lace (Stata or Foreign try) 1and
bu *		Usual Rasidance of Da 10a. Stata t 0	b. County		t0c. C	ity, Town or Lo	cation					1	Od. Insida City Limits
r 28a-f show	Director	74 - 74	Prince (Georges		itol He							1 Yas 2 No
death with the Maryland ms 23a or 28a-f show I must be notified at		10e. Street and Numba	r Ruston A	Avenue			10f. Zip Co	oda			10g. Citizen of U.S.		try?
_ p # 8	by Funeral	1t. Maritel Stetus 1 □ Navar Marriad 3 ☑ Widowad 4 □		12. Was Dece Armed Fo 1 Tes If Yas, Giv Yeer or D	2 X No		Wes Dacedan I Yes, specify I □ Yas 2√		penic Origin? (Spe Maxican, Puento Specify:	acify Yes or No- Rican, atc.)	14. Re Bla	ce - Amaric ack, Whita,	atc.
in 72 hours	Completed	(Specify o	Dacedant's Ed	de complatad)		16a, Daceo (Giva lifa, L	lant's Usual C kind of work of OO NOT usa r	occupationa dui	on ring most of work	ing	16b. Kind of E	Business/Inc	lustry
Maryland 21215-0020 d2 should be filed within 72 hours af th and Mental Hygiene. 7 is marked other than "naturel", or treumatic event, the Med cal Event	Com	Elamantary/Seconda 9 17. Fethar's Nama (Firs		Collega (1	-4or 5+)		icklay	er	8. Mothar's Name		Privat		ustry
aryland should be filed and Mental Hymmarked other americ event,	To Be	Charles		in		-				Walter		ma)	
		19a. Informant's Name. John Wall							d Number or Rura 7., Capi				Coda)
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Baltim pemit. Pag Department important: If any Injury o		21. Signatura of Funara	al Service Licani	lef	Lur	/	Neme end A		Fra	azier F			Inc. D.C.,2000
Physician /Medical Examiner		23e. Pert1. Entar tha d shock, or haart fal Immediata Causa (Fina disaasa or condition rasulting in daath)	al	a. SQ	1515 Dua to (or as a consac	uence of):						Approximeta Intarval Batween Onsat end Death
BOX 68760, eath certificate be executed attanding physician and for use as the burial-transit	cian/Medical Examiner	Sequantially list conditi if any, laading to immac cause. Entar Undartyin Causa (Disaasa or Injur that initiated avants rasulting in daath) Last	ons, diata gg y	o. Righ	Dua to (c) Dua to (c)	or as a consequence to start or as a consequence of the start or as a consequence of the start o	be for unance of):	ne	Pulmo	nary	deso	esce	
Geath death e attar		Part II. Other significan					, ,			23b. Dld t			the cause of death?
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f Vital Rec ysicien: The law is certificate has b director, page 2 s	Compl									1 🗆 Y	as 2 No	of c	leath? I Yas 2□ No
Of Vita Physicien: this certific ral director,	Be	25. Wes casa rafarred t axaminar?	-						6. Placa of Daath	(Check only o	na)		
Of Physics this can direct and direct the can direc	은	1 Yas No				ER/Outpatien		Othar:	4 ☐ Nursing Hor	me 5□ Rasid	lance 6 Oth	har (Specify)
Vision of Attending P or or of Attention of Attention of the tuners by the funers	ation:	2 Accidant	Panding Invastigation	28a. Date of (Monti	f Injury h, Day Year)	28b. Tima of Injury	28c.	Injury at Work? 1 Yas	t s 2 □ No	28d. Dascribe h	ow injury occur	rred	
- X C	Certification:	3 ☐ Sulcida 6 4 ☐ Homicida	Could not be datarmined	28a. Place buildin	of Injury - At h g, atc. <i>(Speci</i> i	oma, farm, stra	at, factory, of	fice	1	28f. Location (S City or Tow	itreet and Numi n, Stata)	ber or Rura	Routa Number,
To the Hospital c within 24 hou.e at To the Funeral D completely filled i	edicai C	29a. Cartifiar (Check only one)	Certifying Phy Medical Exami	alcian: To tha l ner: On tha ba and mann	sis of axamina	owledga, daath ition and/or inv	occurred at the	na tima, my opini	data and place, a on, daath occurre	and dua to tha co	causa(s) and m data and place,	annar as st	atad. the ceusa(s)
To the compl	Me	29b. Signature and title	SI sertific D				29c. Li	cense n	umber	2	29d. Date signe	ed (Month, L	Day, Year)

25.	Wes casa rafarred to madical axaminar?
27.	Mannar of Deeth

29b. Signature and title of gentle

29c. License number D50328

29d. Date signed (Month, Day, Year) April 2071 1597 Apri / 20T

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

Hosp. Dr. Cheverly Md. 20785

State Registrar



APPLE TEREST JUNEA

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				State of Ivia	iryiand /	Certific			d Mental Hy	Reg. No.	97 14796
	Physici	an	1. Decedant's Nama (First, Middla, Las						2. Deta of Da Month	Day	3. Tima of Death Yaar
	/Medio		MARIE KAT	HERINE e street end number)	FLETO	HER	[4b. City, Town,	APRIL or Location of Deat		997 4:10PM
	Funeral Director		GOLDEN OAKS 5. Social Security Number 6. S 212-54-5240		HOME (In yrs. last b	irthday) If U Yrs. Mor	nder 1 Yaar iths Days		Hrs. 8. Data of Bir Min. (Month, Da	th y, Year)	CE GEORGE S 9. Birthplaca (State or Foreign Country)
			Usual Residence of Decedant						FEB.1	6,1910	WASH., DC
	l show	'n	10a. Stata 10b. County	DODGD I G	10c. City, Tov						10d. Insida City Limits XX□ Yas 2□ No
	1 the N	Director	MD PRINCE G	EORGE'S	LAUR		. Zip Coda			10g. Citizan of V	
	th with		9001 CHERRY L	ANE			20707			USA	
020	ould be filed within 72 hours after death with the Maryland Mental Hygiena. Mental Hygiena. Mental Hygiena. Mental Hygiena 23a or 28a-f show afte event, the Mental Examiner must be notified at	by Funeral	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant E Armed Forcas? 1 ☐ Yas 2 ☑ N If Yas, Give Yaar or Datas:		If Yas,	ecedant of H specify Cuba as 2 No	dispante Origini an, Maxican, Pi Specify:	? (Spacify Yas or No uerto Rican, atc.)		e - Amarican Indian, ck, White, etc.
21215-0020	be filed within 72 hours aft tal Hygiena. d other than "natural", or event, tre Medical Eram	Completed	15. Decedant's Ed (Spacify only highast gra Elementery/Secondary (0-12)	lucation da completed) Collaga (1~4or 5-	+)	lifa. DO NO	f work dona OT usa ratire	during most of	working		usinass/industry DOMESTIC
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	ges 1 end t of Health If Itam 27 or other tr		SUSAN B. RAILEY/ 20a. Method of Disposition		20b. Place	of Disposition	(Nama of		LAUREL, N		20707 City or Town, State
altimore,	Pages nent of I ant: If Its ury or o		1 X Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specify			ry, crematory R HILL			5-1-97	SUITLA	ND , MARYLAND
Balt	permit. Page Department of Important: If any injury or once.		21. Signeture of Funaral Sarvica Licen	Bray	ton			ss of Facility			RAL HOME OF MD LAND 20746
F	hysician		23a. Part I. Enter tha disaasa, or comp shock, or haart failura. List only	plicetions that caused one causa on aach lin	tha daath. Do e.	not antar tha	moda of dyir	ng, such as car	dlac or respiratory e	rrast,	Approximete Intarval Between Onset end Death
	/Medical Examiner		Immedieta Causa (Final disease or condition		50	P51	5				1 OAT
		ē	rasulting in daath)		Due to (or as a	consequence	of):				
o'	be axecuted sician and buriel-transit	Examiner	Sequentially list conditions, if any, leading to immadiate cause. Entar Undarlying Causa (Disaase or Injury	b	Due to (or es a	consequence	of):				
0 × 68 / 60	the cate	Medical	Causa (Disaase or Injury that initieted evants rasulting in death) Last	d	oua to (or as a	consequenca	of):				
Box	e atten d for u	iciar	Part II. Other significant conditions co	ontributing to death but	not resulting	n the underly	na causa aiv	ran in Part i	23h Did	tobacco use co	ntributs to the cause of death?
S, P.O	as met me death cerrifications by the attending be datached for use es	by Physician/Me	ORGONIC							Yes 2/2 No	3 Probably 4 Unknown
Records,	ias been si	Completed							24a. Was	an autopsy ormed?	24b. Wara autopsy findings avallebla prior to completion of cause of daeth?
									10	Yas 2000	1 ☐ Yas 2 ☑ No
Vitai	3 3 2	o Be	25. Was casa referred to medical axaminar? 1 ☐ Yas ②☐ No	Hospital: 1 ☐ Inpatian	t 2 ER/O	utantiant 3F	DOA Oth	OP:	Death <i>(Check</i> only only only only only only only only		as (Enseibl)
	After fune	-	27. Mennar of Death 1 Natural 5 Panding 2 Accidant Invastigation	28a. Date of Injury (Month, Dey		Tima of Injury	28c. Injur Wor			how injury occur	
	is after deat al Director: led in by the	Certification:	3 ☐ SuicIda 6 ☐ Could not be 4 ☐ HomIcida datarmined	28e. Plece of Injurbuilding, etc.	ry - At home, for (Specify)	erm, straat, fa	ctory, office		28f. Location (City or To	Street and Numb wn, State)	er or Rural Routa Number,
I Constitution of the cons	within 24 hours after a To the Funeral Directional filled in by	edicai	(Check only 2 Medical Exam	reician: To the best of iner: On the basis of a and manner stet	examination ar	e, daath occur nd/or Invastiga	ition, In my o	pinion, deeth o	ece, end due to the ccurred at tha tima,	data and place,	and due to the ceuse(s)
2	200	Σ	29b. Signature and titla of certifiar				29c. Licans				d (Month, Day, Year)
+			1770		_	1	カフィ	45.3		10011 -	9 1997
(4)		30. Nama end address of person who of Portion of the company of th					-422	. SUITE #		29, 1997 AMEL, MD 20708

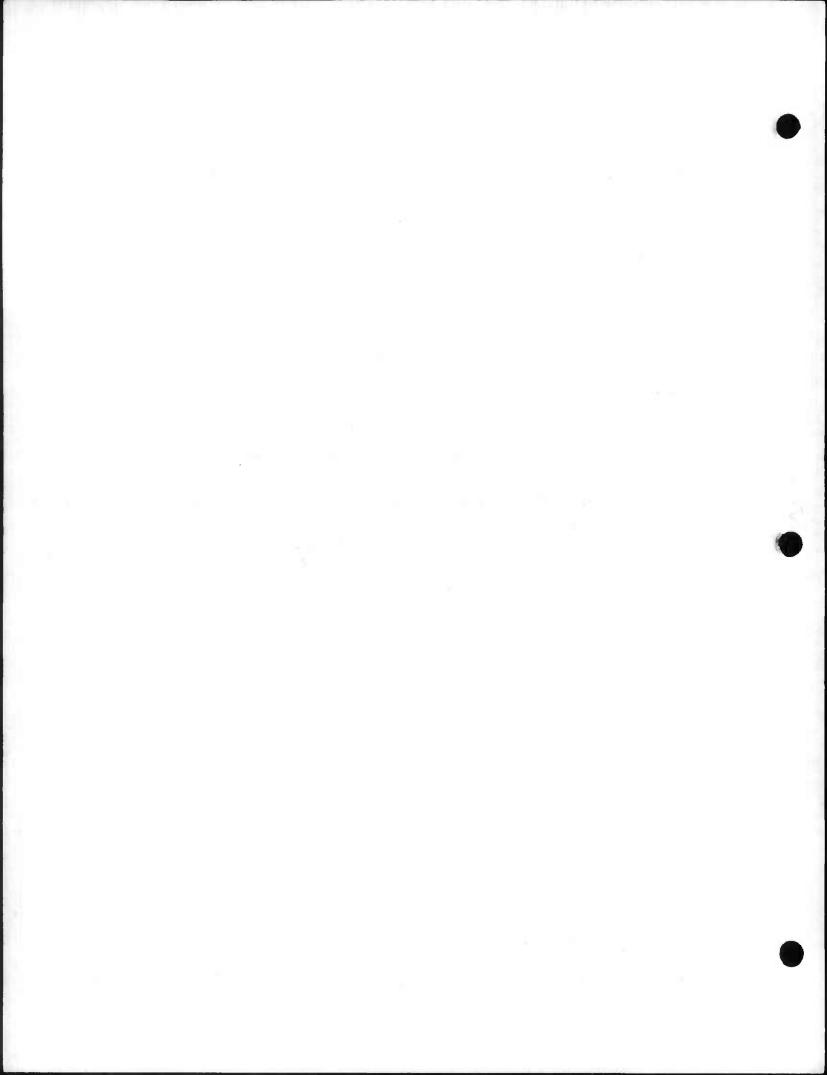
Registrar DHMH 16 Rev 6/95

Children 17 31

State of Maryland / Department of Health and Mental Hygiene

1. Decedent's Neme (First, Middle, Last) Joseph Edga 4e. Facility Neme (If not institution, give served) 8824 Dayton Avenue 5. Social Security Number 220–40–5559 Usuel Residence of Decedent 10a. Stete 10b. County Maryland Calvert 10e. Street and Number 8824 Dayton Avenue 11. Maritel Stetus 1 Never Married 20 Merried	e Towler 7. Age (In yrs. le	Yrs. Months Deys	Hours Min (Month	27, 1997 eth c. County of Deet Calvert	hplaca (Stete or Fore
4e. Facility Neme (If not Institution, give see 8824 Dayton Avenue 5. Social Security Number 220–40–5559 Usuel Residence of Decedent 10a. Stete 10b. County Maryland Calvert 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e.	e X 7. Age (In yrs. le S 10c. City,	Yrs. Months Deys	4b. City, Town, or Location of De North Beach If Under 24 Hrs. 8. Date of it Hours Min. (Month)	4c. County of Deet Calvert Birth Dev. Year) 9. Birth Co	hplaca (Stete or Fore
8824 Dayton Avenue 5. Social Security Number 220–40–5559 Usuel Residence of Decedent 10a. Stete 10b. County Maryland Calvert 10e. Street and Number	e x 7. Age (In yrs. le 52	Yrs. Months Deys	North Beach	Calvert Birth Dev. Year) 9. Birth Co	hplaca (Stete or Fore
5. Social Security Number 220–40–5559 17. Usuel Residence of Decedent 10a. Stete 10b. County Maryland Calvert 10e. Street and Number 2007 P. P. P. P. P. P. P. P. P. P. P. P. P.	7. Age (In yrs. le	Yrs. Months Deys	If Under 24 Hrs. 8. Date of I	Birth 9. Birth	hplaca (State or Fore
Usuel Residence of Decedent 10a. Stete 10b. County Maryland Calvert 10e. Street and Number] M 2□ F 52	Yrs. Months Deys	Hours Min (Month	Birth 9. Birth Co. 13, 1945 Wash	hplaca (State or Fore buntry) 1., D.C.
Usuel Residence of Decedent 10a. Stete 10b. County Maryland Calvert 10e. Street and Number	10c. City,	, Town or Location	Mar 2	3, 1945 Wash	n., D.C.
10a. Stete 10b. County Maryland Calvert 10e. Street and Number					
Maryland Calvert 10e. Street and Number					
	Noi				10d. Inside City Lim
		rth Beach			1 X Yes 2 □ I
		10f. Zip Code		10g. Citizen of What Co	ountry?
2	e		20714	USA	
2 11. Maritel Stetus	12. Wes Decedent Ever in U,S	5. 13. Was Decedent of			rican Indian
1 Never Married 2 Merried	Armed Forces?	If Yes, specify Cut	Hispanic Orlgin? (Specify Yes or liben, Mexican, Puerto Rican, etc.)	Bleck, White	
3 □ Widowed 4 □ Divorced	1 Yes 27 No If Yes, Give 1 Yeer or Detes:	1 ☐ Yes 2 No	Specify:	Specify: whi	+0
		10- 0			
(Specify only highest grade	e completed)	(Give kind of work done	during most of working	16b. Kind of Business/	Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		90)		
		steamiitter	1 2		tion
m .		_	18. Mother's Neme (First, Midd	lle, Meiden Sumeme)	
o Kussell		Fowler	Marion	Iser	nberg
	pe, Print)	19b. Meiling Address (Stree	t end Number or Rural Route Num	nber, City or Town, Stete, 2	Zip Code)
Joyce Broome Fowle	r / wife	same as # 10	above		
20a. Method of Disposition	20b. Ple			20c. Location - City or	Town, Stete
	BUIDABI ILOMI STATA			Dumlai ala	MD
				Dunkirk,	MD
21. Signeture of Funerel Service License	3	22. Neme end Addre	ess of Fecility Rausch F	uneral Home.	P.A.
William J	X/12	- 8325 Mt.			
23e. Part1. Enter the disease, or compli	cetions thet caused the deeth.				Approximete interval Between
Ceuse (Disease or Injury that Initiated events resulting In death) Lest	CAD -		channe Co	sdremyor	Pally
\$ d	COAD				
<u> </u>					
Pert II. Other significant conditions cont	tributing to death but not result	ting in the underlying cause gi	iven in Pert I. 23b. DI	d tobacco use contribute	to the cause of de
			18	Yes 2 No 3 P	robably 4 Unkr
5			100		
<u> </u>				rformed?	Were autopsy findin- available prior to
<u>5</u>					completion of cause of deeth?
5			10	Yes 20 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical			26. Place of Death (Check only	000	
D 1 Yes 25 No	lospitel: 1 Inpatient 2 E	R/Outpetient 3□ DOA Ot	ther: 4 Nursing Home 5 PRe		cifu)
	28e. Dete of Injury 2			e how injury occurred	Gily)
	(Month, Day Year)	Injury Wo	ork?]Yes 2□No		
1 Neturel 5 Pending				(Street and Number or Ru	rel Boute Number
1 Neture 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e Blees of Injury . At hom		ZOI. LOCATION		rai noute reuniber,
1 Neturel 5 Pending Investigation 3 Suicide 6 Could not be determined	28e. Plece of Injury - At hom building, etc. (Specify)	ne, remi, street, rectory, onice	City or 7	OWN, State)	
2 Accident investigation 3 Suicide 6 Could not be determined	building, etc. (Specify)		City or 1		
	building, etc. (Specify) fcfan: To the best of my knowl	fedge, deeth occurred at the ti	City or I	e ceuse(s) end manner as	stated.
29e. Certifier 1 Certifying Physical Check only one) 1 Medical Examin	building, etc. (Specify) fcfan: To the best of my knowl	fedge, deeth occurred at the ti	City or 1	e ceuse(s) end manner as	stated. to the cause(s)
	building, etc. (Specify) fcfan: To the best of my knowler: On the bests of examinetic	fedge, deeth occurred at the ti	ime, dete end place, end due to th opinion, deeth occurred et the time	e ceuse(s) end manner as e, dete and plece, and due	stated. to the cause(s)
29e. Certifier 1 / Certifying Physic (Check only one) 2 Medical Examin	building, etc. (Specify) fcfan: To the best of my knowler: On the bests of examinetic	fledge, deeth occurred at the ti on end/or investigation, in my of	ime, dete end place, end due to th opinion, deeth occurred et the time	e ceuse(s) end manner as e, dete and plece, and due	to the cause(s)
29e. Certifier (Check only one) 29b. Signeture end title af certifier	building, etc. (Specify) Iclan: To the best of my knowler: On the bests of examinetic end menner steted.	Hedge, deeth occurred et the tipon end/or investigetion, in my o	ime, dete end place, end due to th opinion, deeth occurred et the time	e ceuse(s) end manner as e, dete and plece, and due	to the cause(s)
29e. Certifier 1 / Certifying Physic (Check only one) 2 Medical Examin	building, etc. (Specify) Iclan: To the best of my know har: On the bests of examinetic end menner steted. Impleted cause of deeth (Item 2	fledge, deeth occurred et the ti on end/or Investigetion, In my o 29c. Licens 23a) (Type, Print)	ime, dete end place, end due to th opinion, deeth occurred et the time	e ceuse(s) end manner as e, dete and plece, and due 29d. Dete signed (Pont)	to the cause(s)
pe Completed by PhysiciaryMedical Examiner	Elementery/Secondery (0-12) 12 17. Fether's Neme (First, Middle, Last) Russell 19e. Informent's Neme/Reletionship (Try Joyce Broome Fowle 20a. Method of Disposition 1 Buriel 2 Cremetion 3 February 21. Signeture of Funerel Service License 23e. Part 1. Enter the disease, or complishock, or heart feiture. List only or Immediate Cause (Final disease or condition resulting in deeth) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Pert II. Other significant conditions conditions conditions conditions are sulting in death) Lest	12 17. Fether's Neme (First, Middle, Last) Russell 19e. Informent's Neme/Reletionship (Type, Print) Joyce Broome Fowler / wife 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) 21. Signeture of Funerel Service Licensee 23e. Part1. Enter the disease, or complications the caused the deeth. shock, or heert feilure. List only one cause on leach line. Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that inhibited events resulting in death) Lest Pert II. Other significant conditions contributing to death but not result in the cause referred to medical	Steamfitter 12 17. Fether's Neme (First, Middle, Last) Russell Fowler	Elementary/Secondary (0-12) College (1-4or 5+) Steamfitter	Steamfitter Steamfitter Construct

				State of I	Maryland	-	artment <i>rtificate</i>				ental Hy	/giene Reg. No.	97	14798
	z. I.	Ш	1. Dacadant's Nama (First, Middle	a, Last)							2. Data of D	aath		3. Time of Death
	Physici /Medi		Beatrice T. Go	ley							Month April	27, 199	Year 7	9:00 PM
)	Examir		4a. Facility Nama (If not institution	n, give straet and numb	er)			-	b. City, To	wn, or Loc	cation of Dea	th 4c. Coun	ty of Death	
			Holy Cross Hos				T - 2711 1 - 2		Silve	er Sp	ring	Montg	omery	
Н	Funeral		5. Social Security Number	6. Sax 7. 1 ☐ M 2 ☑ F	Aga (In yrs. la	st birthday) Yrs.	If Under 1 Months	Days	if Undar Hours	Min.	8. Data of B (Month, D			elace (Steta or Foraign etry)
	Director		578-52-9048 Usual Residence of Decadant		84					Ų	lan. l	, 1913	Ohio)
	yland		10a. Stata 10b. County		10c. City,	Town or Lo	ocation						1	0d. Inside City Limits
	e Wa	ctor	MD Montg	omery	Silv	er Sp	ring							1 ☐ Yes 2 ☑ No
	ath with the Marylan 23a or 28a-f show	Director	10e. Street and Number			•	10f. Zip C	oda				10g. Citizen o	What Cour	ntry?
	ath w		1714 Tilton Dr	ive			2090					USA		
	er de	Funeral	11. Marital Status	12. Was Deceda Armad Forca	as?	. 13.	Was Dacedar If Yas, specify	nt of H y Cuba	ispanic Orl an, Maxican	gin? (Spe , Puarto F	cify Yes or N Rican, etc.)	o- 14. Ra Bi	ice - Amaric ack, White,	
20	rs eff	by F	1 ☐ Navar Marriad 2 🔀 Marri 3 ☐ Widowad 4 ☐ Divorcad	If Yes Give			1 □ Yas 21	No.	Specify:			Spec	y: whi	te
0200-91212	filed within 72 hours efter death with the Maryland hygiene. uther then "natural", or items 23a or 28a-1 show ent, the Medical Examiner must be notified			t's Education		16a. Dece	dent's Usual (Occup	ation			16b. Kind of	Rusinass/Inc	fustry
ر 12	n "n	Completed	(Specify only highan Elamantary/Secondary (0-12)	st grada complatad)	0. F. \	(Giva lifa.	dent's Usual (kind of work DO NOT usa	done ratired	during most	of workin	ng	100.11110	J 4011 (40 41 11 11	300119
	d with	EO	Elamantary/3econdary (0-12)	College (1-4d	or 5+)	Econ	omist					U.S.	Gover	nment
	al Hygle I other vent, tr	Be (17. Fathar's Name (First, Middla,	Last)					18. Mothe	r's Name	(First, Middle	a, Maiden Sume		
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Maryland	nd 2 should be fi ith end Mental I- 27 is marked ou r traumatic ever		19a. Informant's Name/Raletions	hip (Type, Print)								ber, City or Tow		
	E E E		Pat Olexa 20a. Mathod of Disposition		20h Bla	651	8 Spri	ng	Valle	y Dr	ive, A			A 22312
saimmore,	T IT IT IT IT IT IT IT IT IT IT IT IT IT	1	1 ☑ Burial 2 ☐ Cramation		ata cen	natery, cret	metory or oth	ar plac	•			20c. Location		
	artmer artmer ortant: injury		4 Donation 5 Other (S		Gat		Heaven					Silver	Spri	ng, MD
	Physician /Medical Examiner	(23a Part I, Enter the disease or shock, or heart failure. List Immediata Cause (Final disease or condition rasulting in death)	complications that causonly one causa on aach	Due to (or e	Do not ant	00 Uni	ver	sity g, such as	B1vd cardiac or	respiratory	Silver		Approximate Interval Batween Onset and Death
	bed isit	nine		b	A.	Sayl	mia							
ŕ	ete be executed hysicien and the buriel-transit	Examine	Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying		Dua to (or e	es a consec	quanca of):							
DOX 00/00	ding p	Physiclan/Medical	Causa (Disaase or Injury thet initiated avants rasulting in daath) Last	c	Dua to (or a	is a consaq	uance of):							
	death e etten ed for u	sicla	Part II. Other eignificant condition	ns contributing to death	h but not rasult	ing In the u	nderlving cau	isa niv	an in Part i		23b Die	I tobacco use c	ontribute to	tha cause of death?
5	by the	hys	3			nig in the D	indonying odd	ou giv	un mi junti.			Yes 2 No		
'n	signed by det	by F												
spicoa	requ	ompleted					-				24a. Wa per	s an autopsy omed?	av	ara autopsy findings ailabla prior to mpletion of cause deeth?
	sician: The law certificete has E lirector, page 2 s	Соп									10	Yas 20 No	10	Yas 2□ No
VII	ysician: is certific director,	Be	25. Wes casa rafarred to medica axaminer?							of Daath	(Check only	ona)		
5	Physician: this certific ral director,	To	1 Yas 2 No	Hospital: 1 Minpa		R/Outpatier		-	4 L NU			idanca 6 □O		y)
5	ding Phys h. After this funeral d	ion:	27. Menner of Deeth 1 → Natural 5 □ Pandin	9	njury Day Year)	8b. Time of Injury		Wor	k?		8d. Describe	how Injury occu	rred	
CIVISION	deat ctor: y the	Certification:	2 Accident Invastig 3 Suicida 6 Could 4 Homicide detam	not ba 28e. Plece of	Injury - At hom atc. (Specify)	na, farm, str	M reat, factory, o		Yas 2□I		8f. Location City or To	(Street and Nun own, Stata)	ber or Rura	l Routa Number,
-	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: Atter completely filled in by the fune	edical Co	29a. Certiflar (Check only one) 1 Cartifyin 2 Madical	g Physician: To the bes Examiner: On the basis and mannar	s of exeminetio	edge, death n and/or in	n occurred et vastigation, in	tha tim	na, date end plnion, daet	d plece, e	nd due to the	ceuse(s) and n , date and plece	nennar as si , end due to	ated. the causa(s)
	To the Within To the	Me	29b. Signatura and titla of certifia				29c. L	Licans	e number			29d. Date sign	ed (Month,	Day, Year)
	12		> Calabu A				P	4.	3490	5		4-2	-8-	97
			30. Name and addrass of person Mothammas A	KIMID M.	D 85	330-	Print)	Son	Cou	or !	Silv	128 Sp	ng v	97 10 20910
	Sta		31. Data filed (Month, Day, Year)	997 32. 169	strare Elgnetu	ra 70	00							
DHI	Registr MH 16 Rav 6/9		111111111111111111111111111111111111111	الحد										



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death 3 Time of Death 4b. City, Town, or Legation of Death 0800 AM 4a. Fecility Nama (If not institution, give street and number) 4c. County of Death ROCKVILLE MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL If Undar 1 Year 5. Social Security Number If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Months Days Hours 1□M 2□F TENNESSEE Yrs Usuel Residence of Dacedani 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No ROCKVILLE MARYLAND MONTGOMERY 10f. Zip Coda 10g, Citizan of What Country? 600 VIERS MILL ROAD 20852 UNITED STATES 12. Was Dacedant Ever in U,S Armed Forcas? 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indien, Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: 1 □ Navar Marriad 2 □ Married Specify 3 Nidowed 4 Divorced WHITE 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) TEACHER 5+ ELEMENTARY EDUCATION 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surname) STANSBERRY AT.IIII. GALYON 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANNIE O. ROBINSON, NIECE 19932 LAKE PARK DRIVE, GERMANTOWN, MD 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata A □ Cramation 3 ☑ Ramoval from State APR 29 5 Othar (Specify) WOODLAWN CEMETERY 1997 KNOXVILLE, TN 22. Nama and Addrass of Facility DEVOL FUNERAL HOME 10 EAST DEER PARK DR., GAITHERSBURG, MD 20877 or complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, ist only one causa on each line. Approximata Intervel Batwaan Onset and Death Dua to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consaquance of):

Physician /Medical Examiner

ate has been signed by the attanding p page 2 should be datached for use as

certificate

this funeral

Aftar

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

10

director.

in by tha

or Attending Physician:

To the Hospital

þ

Be Completed

Certification: To

Medicai

Physician

/Medical

Examiner

415-20-4918

10e. Street and Number

ARCHIBALD

1 D Burial

4 Donati

Immediata Causa (Final disease or condition rasulting in death)

25. Was casa raferred to medical

5 Panding

investigation

6 Could not be dataminad

1 Yas 2 No

axaminar?

27. Mannar of Daath

1 Naturel

2 Accidant

3 Sulcida

29e. Cartifias

4 Homicide

21 Signati

10a. State

Funeral

Director

"natural", or items 23a or 28a-f show soical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event, the Modical Example mana

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Director

Funerai

by

Completed

Be 2

with the Maryland

Examiner The law requires that the death cartificate be asscuted tha burial-transit Saquantially list conditions, if any, laading to immediata causa. Entar Undarfying Causa (Diseasa or Injury that initiated evants resulting in daath) Lest pug Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatiant

Data of Injury (Month, Day Year)

23b. Did tobacco use contribute to the cause of death?

1 | Yes 2 | No 3 | Probably 4 | Unknown

24a. Was an autopsy performed?

24b. Wara autopsy findings evailable prior to completion of causa of daath?

1 ☐ Yes 2 No

1 ☐ Yas 2 ☐ No

26. Placa of Daath (Chack only ona)

Othar: 4 Nursing Homa 5 Residence 8 Other (Specify)

28d. Dascribe how injury occurred 28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

🖎 Certifying Physfcian: To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of cartifiar 29c. Licansa number

2 NOutpatient 3 DOA

28b. Tima of

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

3261

29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated causa of attr (Item 23a) (Type, Print) Center 901 edica

William Dool

State Registrar

APR 28



State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

Funeral

Director

the Maryland 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at death with permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "naturel", or iten any injury or other traumatic event, the Medical Examinations. Baltimore, Maryland 21215-0020

> **Physician** /Medical Examiner

physician end the burial-tran Division of Vital Records, P.O. Box 68760, the USB signed by t peen hes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical complately filled in by the funeral director,

Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Day Year April 28, 1997 Eleanor Herzog Grimsley 9:20 PM 4b. City, Town, or Location of Daath 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death Montgomery General Hospital Olney Montgomery 6. Sax 1 ☐ M 2 ☑ F if Undar 1 Yaar It Undar 24 Hrs.
Months Days Hours Min. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Vrs 578-22-4123 85 Jan.8,1912 Washington, D.C. Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☒ No Director Maryland Montgomery Silver Spring 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 20906 U.S.A. Funeral 3163 Adderly Court 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ② No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1 □ Navar Marriad 2 □ Married 1 Yas 2 No Specify: ۵ Specify: 3 ☑ Widowed 4 ☐ Divorced White 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) Secretary Seat Manufacturing 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) Fredericka Otto Herzog Kuno1d 19e. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) Highland, Maryland 6620 Prestwick Drive Richard W. Grimsley 20b. Piaca of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriai 2 DCremation 3 ☐ Ramoval trom Stata 4 ☐ Donation 5 ☐ Othar (Specify) 4/30/97 Alexandria, Virginia Metropolitan Crematory 21. Signature of Puperal Service License 22. Nama and Addrass of Facility 23a. Part 1. Entar tha disaasa, or complications that causad tha death. Do not antar the mode of dying, such as cardiac or respiratory arrast,

Approximate

Approximate Acute Inferior Posterior Myoardial Inferitue Immediata Causa (Final disaasa or condition rasulting in death) Dua to (or as a consequence of):

Second Degree Heart Black

Dua to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaasa or Injury that initiated evants resulting in daath) Last Physician/Medicai Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown þ itval Regurgetation forthe Stenoses 24b. Wara sutopsy findings available prior to completion of cause of daath? Completed TV i Cuerecol Regues station Pulmonic In Sufficiency 1 Yes 22/No 1 TYas 2 THO 25. Was casa retarred to medical axaminar?
1 ☐ Yas 2 ☑ No Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28a. Data of Injury (Month, Day Year) 27. Menger of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accident 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a, Certifiar 12 Certifying Physician: To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29b. Signature and titla of certifian 29c. License number 29d. Data signed (Month, Day, Year) D31918

State Registrar 31. Data filed (Month, Day, Year)

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)
WARREN D. TEVR (5 3305 North Leesque World Boule Ward Silver Fring Mo.Z.) 806 32. Registers Signature
Junia Davidson-Rondelle MAY 01 1997

DHMH 16 Rev 6/95

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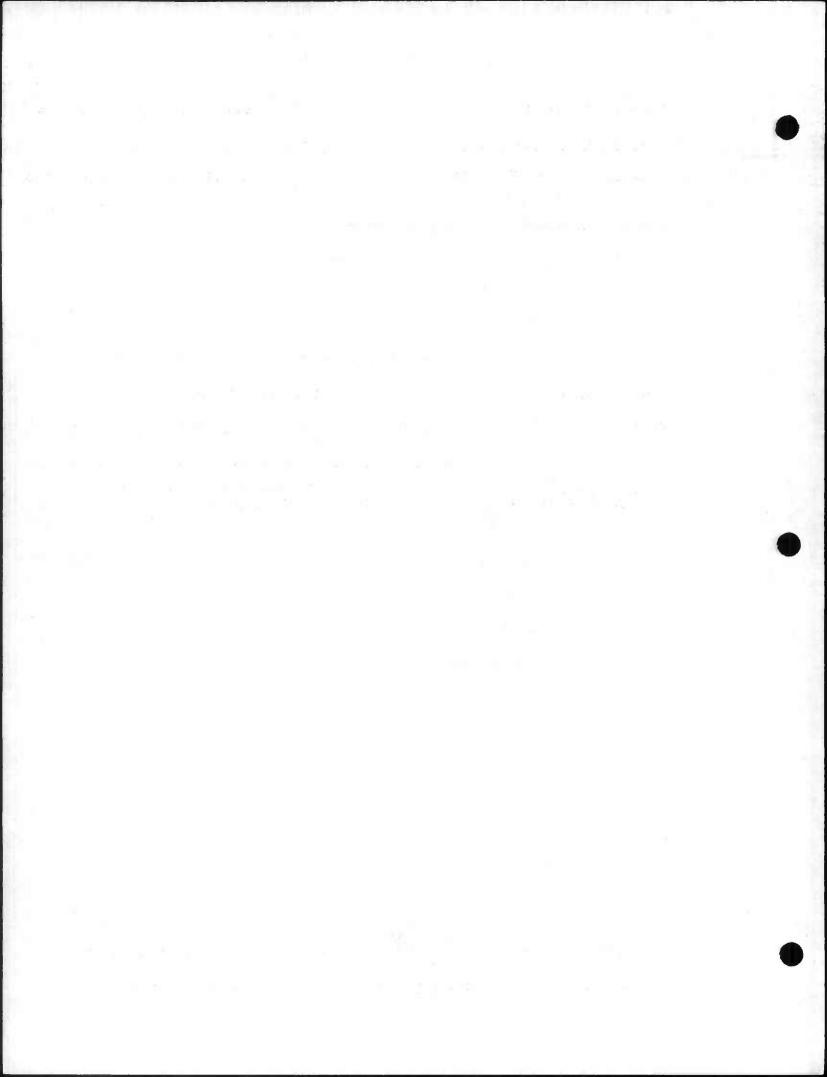
State of Maryland / Department of Health and Mental Hygiene

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							C	ertifica	te of	Deat	n		Reg. No.			
Г	Dhuaia		1. Decedant's Nama (First, Mid	dla, Las	st)							2. Data of D	eath Day	Yaar	3. T	ima of Deeth
	Physic /Medi		Katherine W. Gnall							April			26, 1997		1:	:30 AM
	Exami		4a. Facility Nama (If not institut	ion, give	a straat and nu	ımber)				4b. City,	Town, or L	ocation of Das		ounty of Deat		
			Bedford Court	Nur	sing Ce	enter				Silver Spring Montgomery Year If Undar 24 Hrs. 8, Data of Birth 9, Birthplace /S						
	Funeral		Bedford Court Nursing Center 5. Social Sacurity Number 6. Sax 7. Aga (In yrs.				rs. last birthda	// If Und Months	er 1 Year	If Und	ar 24 Hrs.	8. Data of B	irth	9. Birt	hplace (S	Stata or Foraign
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	r 28a-f show	a.	10a. State 10b. County 10c. City, Town or Location											-	sida City Limits	
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	or 28	Director	10e. Street and Number			ip Coda				10g. Citiza	n of What Co	untry?				
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	vurs after death v st', or items 23s Examiner man	Funeral	11. Marital Status			edant Evar in	U,S. 13	. Was Dac	edant of H	ant of Hispanic Origin? (Specify Yas or N ify Cuban, Maxican, Puarto Ricen, atc.)			14. Race - Amaricen Indian, Black, Whita, atc.			ian,
Maryland 21215-0020	72 hours after netural!, or its		1 ☐ Navar Marriad 2 ☑ Ma	arried	1 🗌 Yas	2 X No										
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	of Health item 27		20e. Mathod of Disposition			20b	. Place of UIS	position (/vi	ama or		er s	ilver Data	20c. Loca	tion - City or	Town, St	_ZU9UZ
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	requires that tha death een signed by the atter hould be detached for t	Physicia	Part II Other significant condit	ione co	ntributing to d	eath but not re	acultina in the	undadulna	cours ai	on in Par	4.1	22h Die	f tobecoo un	a contribute	to the o	ours of death?
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	f or Attendil after death. Director: A In by tha fu	110	3 ☐ Suicida 6 ☐ Could 4 ☐ Homlcida datar	of Injury - At		traat, facto	ry, office			28f. Location (Street and Number or Rural Routa Number,						
	スモーニ	Certification:	4 Hornicida		bulla	ing, atc. (Spec	ciry)					City or Town, Stata)				
	To the Hospital or Attent within 24 hours after deat To the Funerel Director: complately filled in by tha	aic	29a. Certifiar 12 Certify	ing Phy	aician: To the	best of my kr	nowledga, daa	th occurre	at tha tir	ne, date a	and plece.	and due to the	e cause(s) an	nd mannar as	stated.	
	Pu Fu	edicai	(Check only 2 Medica one)	t Exam	Inar: On tha b	esis of axamir nar stated.	nation and/or	nvastigetio	n, In my o	pinlon, de	ath occur	ed at tha tima	, data and pl	ece, and due	to the ca	ause(s)
	offinithin offin omp	M	29b. Signatura and title of certifi	ar	4			25	c. Licans	a numbe		T	29d. Data s	signed (Monti	n, Day, Y	'ear)
	~ S F O		MRF	(1	my b	7	WM		D 1-	700			29d. Data signed (Month, Day, Year)			
	4	-		00	, me c				D 17	/29			April	28, 1	997	
	U		30. Neme and addrass of person	n who c	ompleted caus											
			G. B. Patrick,	III	[, M.D.	9221	Coles	ville	Roa	d Si	Lver	Spring.	Mary	land 2	0910	
	Sta		31. Data filed (Month, Day, Year			Registrar's Sign	natura	2m1.00	0							
	Registr	ar	MAY U	T 13	197	Juna va	w/4001//	- Incore								
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 4802 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** 1997 Helen Louise Geiman May 11:30 a.m. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 18 Fitzhugh Avenue Westminster Carroll If Undar 1 Yaar | If Under 24 Hrs. Months | Deys | Hours | Min. 5. Sociel Security Number Birthplaca (Stata or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys 1□M 2**⊠**F 212-24-6397 73 Yrs. Jan. 19, 1924 Director Virginia Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or hams 23a or 28a-f show event, the Modical Examiner must be nutified at MD Carroll Westminster 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Coda permit. Peges 1 and 2 should be filed within 72 hours after death with the Department of Heelth and Mentel Hygiene. Important: If frem 27 is marked other than "natural" any Injury or other traumatic averages. 10g. Citizen of What Country? 18 Fitzhugh Avenue 21157 United States Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Never Merried 2 Merried 1 ☐ Yas 2 ☒ No If Yas, Give Yeer or Detes: 1 ☐ Yas 2 ☑ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed Decedent's Usual Occupation
 (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilega (1-4or 5+) salesperson furniture store 12 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meidan Sumama) Be Edward Hitchcock Vosburgh Iva Estella Riggall 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Carl Eugene Geiman, husband 18 Fitzhugh Ave., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 05/05/97 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Westminster Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Westminster, MD 21. Signature of Funerel Sarvice Licensee 22. NPritts arafaferal Home & Chapel * Katrerine Pritts - Sweitzer 412 Washington Rd., Westminster, MD 23e. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in daeth) Examine Dua to (or as a consequence of). Hospital or Attending Physician: The law requires that the deeth certificate be executed
24 hours after death.
 Furneral Director: After this certificate has been signed by the attending physician and
alely filled in by the funeral director, page 2 should be deteched for use as the burlansit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Diseesa or Injury that initiated events resulting in deeth) Last Due to (or es e consaguance of) Division of Vital Records, P.O. Box 68760, by Physician/Medicai Dua to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? 1 TYes 2 No 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical 28. Pleca of Daath (Check only ona) Other: 4 ☐ Nursing Homa 5 🗷 Residence 6 ☐ Othar (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deeth 28e. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Dascribe how Injury occurred 1 Neturei 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28a. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Dis completely filled in 1 Certifying Physician: To the best of my knowladge, deeth occurred et the time, data and piace, and dua to the cause(s) and menner as steled.

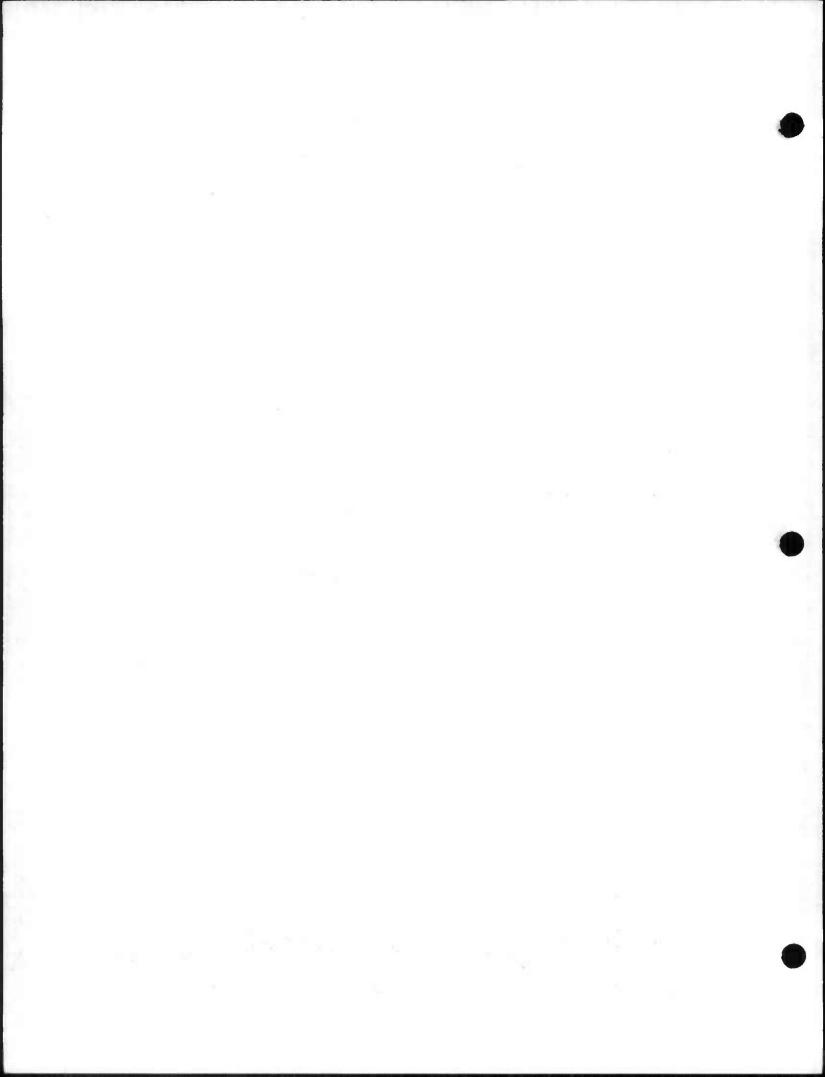
| Medical Examiner: On the best of examination end/or invastigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29a, Cartifier edical 29b. Signatury and take of contains 29d. Data signed (Month, Day, Year) MAY 5 1997

State Registrar WESTMINSTER MD 21157

30. Nema and addrass of person who completed cause of deeth (Item 23e) (Type, Print)

DEAN H GRIFFIN

31. Dete filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

14803

				Ce	rtificate of	f Death		Reg. No.	1	14003	
Physicia		1. Decedant's Nama (First, Middla, L	ast)				2. Data of Das Month		Year	3. Tima of Death	
Physician /Medicai		Marguerite		April	and the second s		8:00 PM				
Examine		4a. Facility Nama (If not institution, g	4b. City, Town, or								
		Manor Care Poto	omac			Potomac		Mon	tgome	ry	
Funeral Director		5. Social Security Number 6. Sax 1 M 2 F 6. Sax 7. Aga (In yrs. last birthday) Yrs. Months Days Hours Min. B. Data of Birth (Month, Day, Year) December 21, 193							9. Birthplaca (Stata or Foraign Country) Washington, D.C		
*		Usual Rasidance of Dacadant 10a. Stata 10b. County 10c. City, Town or Location									
of a b	2	District of Col		o. ony, roun or E	Washing	rton			10	od. Inside City Limits 1 ☑ Yas 2 ☐ No	
188	ect	10e. Street and Number	I dilib I a		10f. Zip Code			10- 011			
23a or	rai Dir	4217 East Capi				States					
is marked other than "natural", or frame 23a or 28a-f show reumatic evant, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Navar Marriad 2 □ Marriad 3 □ Widowad 4 □ Divorcad	If Yas Giva A		.S. 13. Was Decedant of Hispanic Origin? (Spailf Yas, specify Cuban, Maxican, Puarto F			city Yas or No- Rican, atc.) 14. Hac Bla		ca - American Indian, ack, Whita, atc. Black	
Isal	sted	15. Decedent's E (Specify only highest g	ducation	16a. Dece	dant's Usual Occ	upation	rking	16b. Kind of Businass/Industry			
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P 2	5	12			Secretary			Go	Governmen		
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arke atic	2	Lindsay C. Muri	ray	Mary Coe							
other traumatic		19e. Informant's Name/Ralationship	(Type, Print)	19b. Mail	ing Addrass (Stree	et and Number or Ru	ural Routa Numbe	r, City or Town,	Steta, Zip	Code)	
n 27 ser tr		Ella M. Murray				St., N.W.	-Apt. 21	1; Wash	., D.	c. 20009	
20 00		20a. Mathod of Disposition 1 □ Burial 2 □ Cramation 3 [Placa of Disponentary, cra 	osition (Nama of matory or othar p	ace)	Data	20c. Location	- City or Tov	vn, Stata	
ת'א		4 ☐ Donation 5 ☐ Other (Spec		Washington	n National	Cemetery	4/28/97	Suit	land.	MD	
Important: If Item 27 is any Injury or other tra once.		21. Signature of Funeral Service Lice	ensee A		2. Nama and Add		Stewart				
= = 0		Mary / Ste.	was III	4	001 Benn	ning Rd.,	N.E.; Wa	ashingt	on, D	.C. 20019	
sician edical miner	her	23a. P.M. Enter the disease, or constroot, or heart failure. List only Immediate Cause (Finel disease or condition resulting in death)	a. Re	espirator to (or es a consa	ry arrest					Approximata Interval Between Onsat and Death	
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ing prysician end	Medical Exa	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents rasulting in daeth) Last	C	to (or as a consec							
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6	9	25. Was casa refarred to medical				26. Plece of Dec	eth (Check only or	na)			
o o	0	axaminar? Hospital: 1 Dispetient 2 SP(Outpetient 3 DOA) Other: 4 St No.)	
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omple de la comple		29b. Signature and title of pertifier	/ / 0.	11/- 4	1 2 29c. Licar	sa number	1 2	29d. Data signe	d (Month, D	ay, Year)	
		Marie Landon Start									
	-	D14888 April 30,							, 199	7 (
/		30. Nama and addrass of person who Nikolaus Mendj				a Avenue,	, N.W.,Wa	ashingto	on,D.	20037	
State	-	31. Data filed (Month, Day, Year)	32/Registrar's S		1						
Registra	r	MAY 02 195	AS SEAL OF CHARLES	ACT AMENDS	•						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month 3:05 AW GRIFFIN AHTSIANN MAY 1997 /Medical 4e. Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Laurel Regional Hospital Laurel Prince George's 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Dey, Year) Birthplace (Stata or Foraign Country) **Funeral** Months Days 1 □ M 2 1 F 212-64-1868 57 Yrs Director 03-09-40 Maryland Usual Rasidance of Decedant the Maryland 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show trsumatic event, the Medical Examiner inset be notified at Director Maryland Prince George's DOYas 2 No Laurel 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? ŏ Нетв 23а 13004 Old Stage Coach Road #1015 20708 USA daath Funeral 12. Was Decadant Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, etc.) Rece - Amaricen Indian, Black, White, etc. should be filed within 72 hours after on Mental Hygiena.

merked other than "natural", or ites 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 200 No Specify: Black þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilega (1-4or 5+) Government Custodian 9th permit. Pagas 1 and 2 should be file Department of Haalth and Mental Hy Important: If Item 27 is merked other any injury or other traumatic event page. 17. Fethar's Nema (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Surnama) Daniel Matthew Griffin Mary Elizabeth Corbert 19a. Informant's Neme/Raiationship (Type, Print) 19b. Meiling Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Joyce Griffin/Daughter 6531 Hillmar Drive #102, Forestville, MD 20747 20b. Place of Disposition (Name of cemetary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State ₽Deurial 2 ☐ Cramation 3 ☐ Ramoval from Stata Harmony Memorial Park 5/9/97 Landover, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensee 22. Nama end Address of Fecility J.B. Jenkins Funeral Home Nanc A. Percenti 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Entar tha disassa, or complications that caused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Batween **Physician** /Medical Immediete Ceusa (Final diseesa or condition rasulting in daath) **Examiner** Examiner tension attanding physician and for usa as the burial-transit The law requires that the death cartificate be axecuted Sequantially list conditions, if eny, laading to Immadiata ceuse. Entar Undarlying Causa (Disaasa or injury that initiated evants rasulting in deeth) Last Dua to (or as e consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of). ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed t Records. ģ paga 2 should Completed 24b. Wera autopsy findings eveilebla prior to 24a. Was an eutopsy performed? completion of causa of death? this certificata 2 No 1 ☐ Yas 2 ☐ No of Vital or Attending Physician: director, Be 25. Was cese rafarrad to medicel axaminer? 26. Placa of Deeth (Check only ona) To the Hospital to within 24 hours after death.
To the Funeral Director: After this committee filled in by the funeral directors. Hospitel: 1 ♣ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 2 1 ☐ Yas 2 No Certification: 27. Mannar of Deeth 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Neturel 2 Accident 5 Panding Invastigation 1 Yas 2 No 3 ☐ Sulcide 6 Could not be datamined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicida 1 Certifying Physician: To the best of my knowledge, daath occurred et the time, dete and place, and due to the ceusa(s) and mannar as steted.

| Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, daath occurred at the time, data and place, and due to the ceusa(s) and mannar stated. 29e. Certifier Medical (Check only one) 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Dey, Year) who complated ceuse of death (Item 23a) (Type, Print) 321 Prince Georg Street 31. Data filed (Month, Day, Yaar) 32: Ragistrar's Signetura State

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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H	Exami	ner	4a. Facility Name (If n	ot institution, gi	va street and n	um <i>ber)</i>					ocation of Deel	-			
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	pu *	Director	Usuel Residence of D	ecedent 0b. County		10c C	ity, Town or Lo	ncation					**	Nel Japaida Olbe I Imite	
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Division of Vital	l or Attending lafter death. Director: After in by the fune.	Certification:	4 Homicide	determined		ting, etc. (Special	eet, lectory, onic	9		City or To	ity or Town, State)				
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Daath **Physician** Gaines APRIL 97 8:00 Am Annie 26 /Medical 4a. Facility Nama (If not Institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGES MEDICAL CENTER CHEVERLY PG 8. Data of Birth Month Dey, Year) 3/3/22 5. Social Sacurity Number If Undar 1 Year If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 9. Birthpleca (Steta or Foreign **Funeral** 1□ M 2☐¥F Davs Hours CAMPBELL CY, VA 227-22-6475 75 Director Usual Residence of Dacadent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show ral', or itama 23a or 28a-f shov Examiner must be notified at 10d. Insida City Limits DC N/A WASHINGTON Director Yas 2□No 10e. Street end Numbar 10f. Zin Coda 10g. Citizen of What Country? 73 UNDERWOOD PL NW 20012 USA Funeral 12. Was Decadant Ever in U,S. Armad Forces? 1 ☐ Yas 2 ☐ No If Yas, Give 11. Marital Status Was Decedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Ricen, atc.) 14. Rece - American Indian Pages 1 and 2 should be filed within 72 hours atter and of Healith and Mental Hygiona. Int: If Item 27 is marked other than "natural; or ite ury or other traumatic event, ite Model English 1 Naver Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No þ Spacify: Specify: BLACK XXWidowed 4 □ Divorced Yaar or Datas: Completed 15. Decadant's Education (Specify only highast grade complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Collega (1-4or 5+) NONE Elementery/Secondary (0-12) 12 YEARS FEDERAL EMPLOYEE (GPO) PRINTING(GOVERNMENTAL) 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumema) Be CLYDE GRAVES EULA HUBBARD 19a. informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) WENDY CARRINGTON (DAUGHTER) SAME AS 10A, B, C, D, E, &F 20b. Place of Disposition (Nama of cematary, cramatory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, Stete permit. Pages Depertment of important: If it any Injury or or 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from State ARLINGTON NATIONAL CEMETERY 5/5/97 ARLINGTON, VA. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funerel Sarvice Licensaa 22. Nama and Address of Facility JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017 23a. Part. Entar the disaasa, or complications that caused the deeth. Do not antar the mode of dying, such as cardiec or respiratory arrast, show, or heart fellura. List only one cause on each line. Physician /Medical Immediata Cause (Final disaasa or condition rasulting in daath) Heurt Examiner - n Known Dua to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit oronary Sequantially list conditions, if any, leading to immedieta ceusa. Enter Undarlying Causa (Diseasa or injury that initiated events rasulting in daeth) Last Dua to (or as e consaguance of) P.O. Box 68760, Physician/Medical Due to (or as a consequance of): USB signed by the at t be deteched for Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa givan in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown beleg hellitzs Records, þ 24b. Ware autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy Hy per tension Status Post Carchiac ARMest loss of Conticue 1 □ Yas
26. Place of Daath (Check only ona) certificate 2 (B) 1 ☐ Yes 2 ☐ NO of Vital or Attending Physician: 25. Was cesa raferred to medicel axaminer? Hospitel: 1 Impatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 2 1 Yas 2 No 5 ☐ Rasidence 6 ☐ Other (Specify) s after death.

i Director: After this od in by the funerel di this 27. Manner of Death Medical Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Division 5 Pending investigation 1 Neturel 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, straet, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homleida Hospital c 24 hours at Funeral D 29a. Certifian 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and mannar as stated. To the Hosp Within 24 hos To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signetura and titla of certifit 29c. Licanse number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) STEPHEN George's Hospital J KAT 31. Data tiled (Month, Day, Year) 32. Ragistrar's Signetura State the atwar Rand !! Registrar

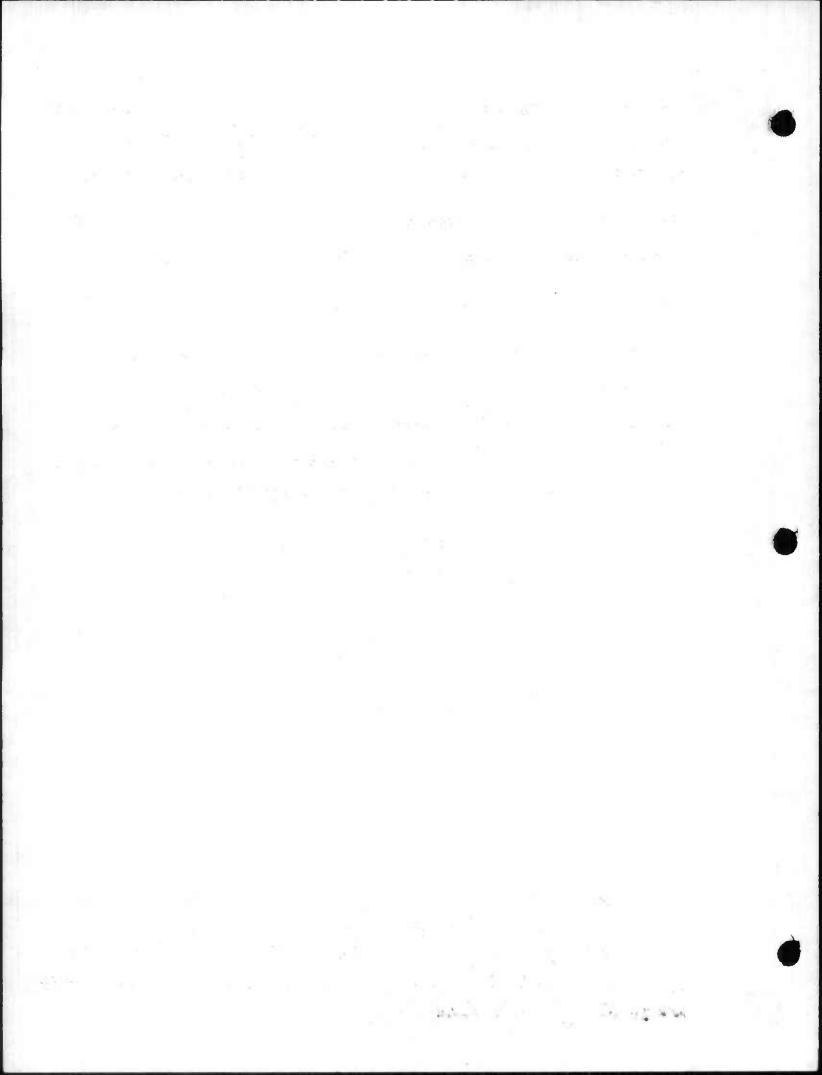
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 10 0/10 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Month e1 199 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Sedv Trince George enter hever 14 If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 177 M 20 P Months Deys Hours Director 424-10-1202 Yrs 82 OCT 9, 1914 ALABAMA Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10e. Stete 10h County 10c. City, Town or Location 10d. Inside City Limits me 23a or 28a-f show Director 1 Ves 2 □ No N/A N/A WASHINGTON, D.C. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5055 First Street, N.W. #303 20011 Funeral United States Heme : 12. Wes Decedent Ever in U,S. Armed Forces?

1∆ Yes 2□No If Yes, Give Yeer or Dates: 42-63 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. "natural", or iten 1 ☐ Never Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 No Completed by Specify: 3 Widowed 4 □ Divorced BLACK Pages 1 and 2 should be filled within 72 ho ment of Health and Mental Hygiene. snt: If Item 27 is marked other than "natur ury or other traumatic avent, in a Ment call. 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Private Stock Clerk Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Lee Griffin Julia Daniels 19a. Informent's Name/Relationship (Type, Print) Niece 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Geraldine K. Bennefield/ⁱⁿ law 12408 Lytton Avenue, Brandywine, Md. 20613 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑Burial 2 ☐ Cremation 3 ☐ Removel from Stete permit. Page Depertment of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Arlington Nat. Cemetery | 5/1/97 Arlington, Virginia 21. Signature of Fuperal Service Licens 22. Name and Address of Fecility ALEXANDER S. POPE FUNERAL HOMES M859 5538 Marlboro Pike, Forestville, Maryland 20747 29a. Pert1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth Physiclan /Medical Immediate Cause (Final disease or condition resulting in deeth) 10.00 ease ONAVU Examiner V Due to (or es e consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last the burial-tran Due to (or es e consequence of): P.O. Box 68760, ettending physician I for use es the buria Physician/Medicai Due to (or es e consequence of) igned by the air Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert f. 23b. Dfd tobacco use contributs to the cause of death? been signed by 1 Yes 2 No 3 Probably 4 2 Unknown Division of Vital Records, þ Completed 24a. Wes en autopsy performed? 24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? certificate has 1 Yes 2DING 1 ☐ Yes 2 ☐ No thursidism 00 or Attanding Physician: Be 25. Was case referred to medical examiner 2 □ No 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) Certification: 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 PNeturel deeth. 1 ☐ Yes 2 ☐ No 2 Accident Within 24 hours after deet To the Funeral Director: 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 3 28f. Location (Street and Number or Rure! Route Number, City or Town, Stete) 4 Homicide Hospital 1 Contifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) end menner steled. 29e. Certifier Medicai (Check only the METINA 29b. Signetyre and title of certified 29c. License number 2 29d. Dete signed (Month, Dev. Year) My and address of person who completed ceuse of death (Item 23e) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State APR 30

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	Physici /Medi		Decedeni's Name (First, Middle, Las	Harry F.	Hannascl	h		2. Deta of De Month April	Dey	Year 7	3. Time of Death 10:00 PM	
į.	Examir		4a. Facility Neme (If not institution, give Carriage Hill-Be				4b. City, Town, or I Betheso			of Death	У	
7	Funeral Director		193-07-7816A	M PDE	s. last birthday) 7 Yrs.	# Under 1 Year Months Deys	If Undar 24 Hrs. Hours Min.	8. Dete of Bir (Month, De March	th ay, Year) 2, 1900	9. Birthp Coun I OV	eca (Stata or Foreign try)	
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	with the	Directo	10e. Sireet and Number			10f. Zip Code			10g. Citizen of V	Whet Coun	try?	
020	n 72 hours efter death with the Maryland "natural", or items 23a or 28a-f ahow disal Examiner must be notified at	by Funeral	5215 West Cedar I 11. Maritel Status 1 Never Marriad 2 Married 3 Widowed 4 Divorced	Jane 12. Wes Decedent Ever in the Armad Forces? 1 ☐ Yes 2 No If Yes, Give Year or Detes:		20814 Vas Decedent of H Yas, specify Cuba □ Yes 2⊠ No	lispanic Origin? (S an, Mexican, Puart Specify:	pecity Yes or No o Rican, etc.)		4. Race - American Indian, Black, White, etc. Specify: White		
121	d within giene. r than	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondery (0-12) 1 2	cation le completed) College (1-4or 5+)	16e. Deced (Give k life. D	ent's Usuel Occup kind of work done of OO NOT use retired Buyer	ation during most of wor i)	king	16b. Kind of Bu	usiness/inc		
yland	P d la	To Be C	17. Falher's Neme (First, Middle, Last) Frederick Hannasc	h				8. Mother's Name (First, Middle, Maiden Surmama) Elizabeth Puettmann				
iore, Mar	th and th and 7 Is m traum		19a. Informent's Neme/Relationship (T) Frederick H. Hanna 20a. Method of Disposition 1□ Bunal 2□ Cremation 3□F	sch/Son 20b.	10664 Plece of Dispos cemetery, crem	N.W. 16 sition (Name of alory or other place	Court, I CApril 28	Plantati	-	rida	33322	
Baltimore,	permit. Pages 1 en Department of Hee Important: If Item 2 any Injury or other ance.		4 □ Donetion 5 ☑ Other (Specify) 21. Signature of Funeral Service Licens	Entombment Ga	198 Rol	Heaven Ma Name and Address bert A. 1 557 Wisco	usoleum Pumphrey Onsin Ave Maryland	Funeral			Maryland da-Chevy se, Inc.	
di.	Physician /Medical Examiner		23a. Part1. Ente ne disease, or compi shock, or hart feilure. List only of Immediate Ceuse (Finel diseasa or condition	lcations that caused the deen cause on each line. Acute Rena	eth. Do not ente	r tha mode of dyin	g, such es cardlac	or raspiratory e	rresi,	2-	Approximate Intervei Between Onset end Daath	
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68760,	ficate be executed physician and is the bunal-transit	edicai Exan	Sequentially list conditions, if any, leeding to immediate cause. Enler Undarlying Ceuse (Disease or injury that initiated events resulting in death) Last	Ye	ears							
X Q Q	ath certif	Physician/Me								1		
ت 5	requires that the de- een signed by the a hould be deteched f	by Physic	Pert II. Other significant conditions con Atherosclerotic He						tobacco use cor Yes 2☑ No		the causa of death? ably 4 Unknown	
Tecords	The law requires ate has been sign page 2 should bo	Completed b	Gout, Macular Deg	eneration Bli	ndness,	Osteoar	thritis		an eutopsy rmed?	ava	ore eutopsy findings ilable prior to npletion of cause death?	
VITAL	certificate ha	Be	25. Wes case referred to medical exeminer?	lospitel:		2□ DOA Othe	26. Piece of Dee	th (Check only o			Yes 21X No	
DIVISION OF VITAL RECORDS,		Certification: To	27. Menner of Death 1 Netural 5 Pending investigation 3 Sulcide 6 Could not be	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 La Nursing Ho	28d. Describe I	dence 6 Other	ed		
2	spital or A nours after neral Dire y filled in b											
	within 24 hours at To the Funeral D completely filled i	Medicai	(Check only 2 Medical Examirone) 29b. Signeture and title of certifier	er: On the basis of examine end menner steted.	etion and/or Inva	29c. Licanse	olnion, deeth occur	red at the time,	dete and plece, a	ind due to	the cause(s)	
!	20		30. Nama and eddress of person who co	mpleted cause of death (Iter	m 23e) (Type, P	D355	79		4/2	5/97		
	Stat		Susan J. Miller, 1 31. Dete filed (Month, Day, Year) APR 2.8 1997		nsin Ci	rcle, Ch	evy Chas	e, Mary	land 20	815		

State of Maryland / Department of Health and Mental Hygiene

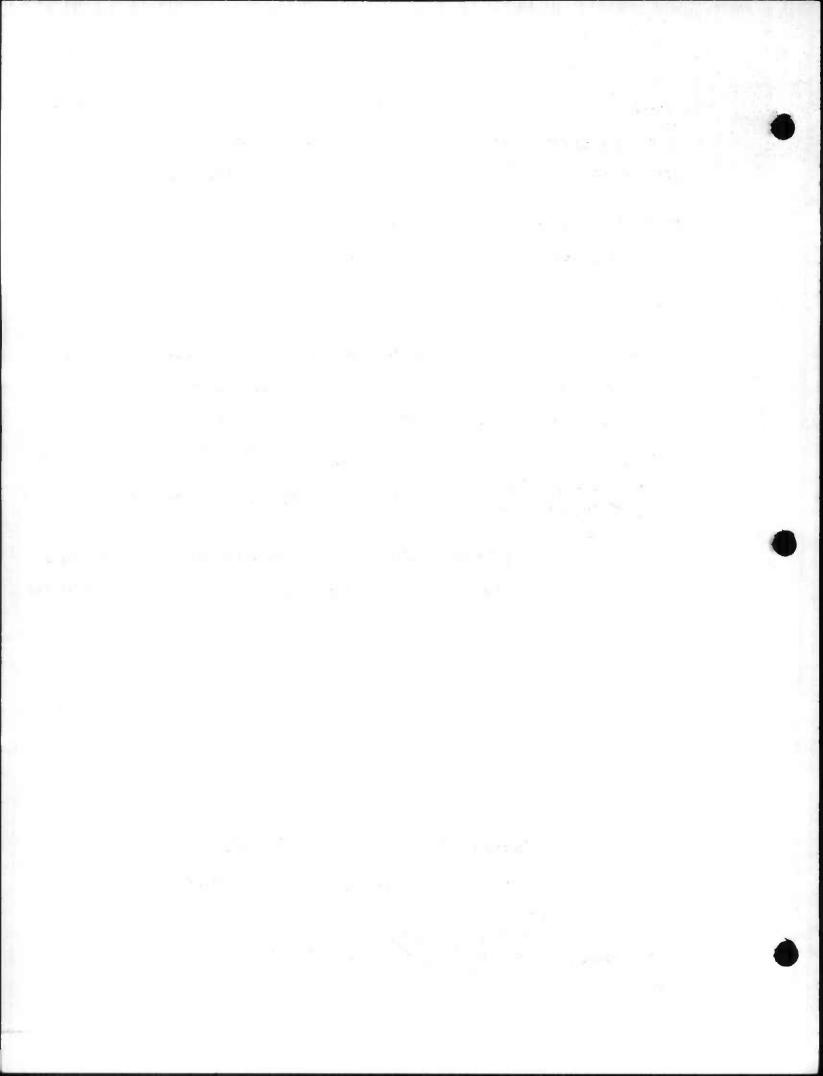
Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Dey 1997 Month **Physician** GRACE HUFF APRIL 26, Gordon 6:00 PM /Medical 4e. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WILSON HEALTH CARE CENTER GAITHERSBURG MONTGOMERY If Under 1 Year If Undar 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthpiaca (State or Foreign Country) **Funeral** Months 1□M 2፟ F Vre Director 578-07-4056 87 Sept. 27, 1909 Nebraska Usuel Residence of Dacadant the Maryland show 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or Items 23s or 28s-f show traumetic event, the Modical Examiner insist be intiffied at 1√ Yes 2 No Director Maryland Montgomery Gaithersburg 10e. Streef and Number 10f. Zip Coda 10g. Citizen of Whet Country? 211 Russell Avenue 20877 Funeral United States death 12. Was Dacedenf Evar in U,S. Armed Forcas? 13. Wes Dacedant of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 11. Marital Stefus 14. Race - Amarican Indian, permit. Pages 1 and 2 should be filed within 72 hours after Department of Haalth and Mental Hygiane. Inportant: If Item 27 is marked other than "natural", or then any Injury or other traumatic event, the Medical Eventua Black, White, etc. 1 ☐ Yas 2X No If Yas, Giva 1 Navar Marriad 2 Marriad 7€.

■ Baltimore, Maryland 21215-0020 1 Yas 2X No Specify: ð f Yas, Giva Yaar or Datas: 3 ₩ Widowed 4 Divorced White 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Office Manager Civil Engineering 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) James M. Seybolt Iva Clair Nelson 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winifred G. Green (Daughter) 1001 East Oregon RD. Lititz, Pa. 17543 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata № Cramation 3 Ramoval from State 1 X Burial April 30 4 Donal 5 Othar (Specify) Ft. Lincoln Cemetery Brentwood, Maryland 1997 21. Signeture of Funarel Service Dicensee 22. Name end Addrass of Facility DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD 20877 e, or complications that ceused tha death. Do not entar tha moda of dying, such as cerdiac or raspiratory arrasf, List only one cause on each line. Approximeta Intarval Betwean Onsat and Death **Physician** PULMONARY EMBOLISM

Due to (or as a consequence of):

FRACTURE FEMUR /Medical Immediate Cause (Final disaasa or condition rasulting in death) Examiner Examiner 4 WKG sician and burial-transit Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disease or injury that initiated evants resulting in death) Last P.O. Box 68760. ding physician ise as the buria that the death certificate be Physician/Medical Dua to (or as a consequence of) as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☐ Unknown Division of Vital Records. þ 24b. Wara autopsy findings evailabla prior fo completion of ceusa of death? Completed 24a. Was an autopsy performed? 1 Tyes 2X No. 1 ☐ Yas 2 ☐ No certificate I or Attending Physician: after death. Director: After this certifica Be 25. Was case refarred to medical 26. Place of Death (Check only one) axaminer? 1⊠ Yas 2□ No Hospitai: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Dascribe how injury occurred 5 Pending investigation 1 Natural 1 Yas 2 No Accident MARCH 3197 F-ELL 6 Could not be datamined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At homa, farm, straet, factory, office building, atc. (Specify) 4 Homleide To the Hospital o within 24 hours af To the Funeral Di completaly filled in NURSING Home 29a, Cartifian 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and placa, and dua to the causa(s) and mannar as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signetura and tale of Surprier 29c. Licansa numbar 29d. Data signed (Month, Day, Year) 007099 30 April 28, 1997 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Francis C. Mayle, M.D., 10215 Fernwood Road, #301 Bethesda, MD 20817-1106 31. Date filed (Month, Day, Year) 32. Ragistras Signature

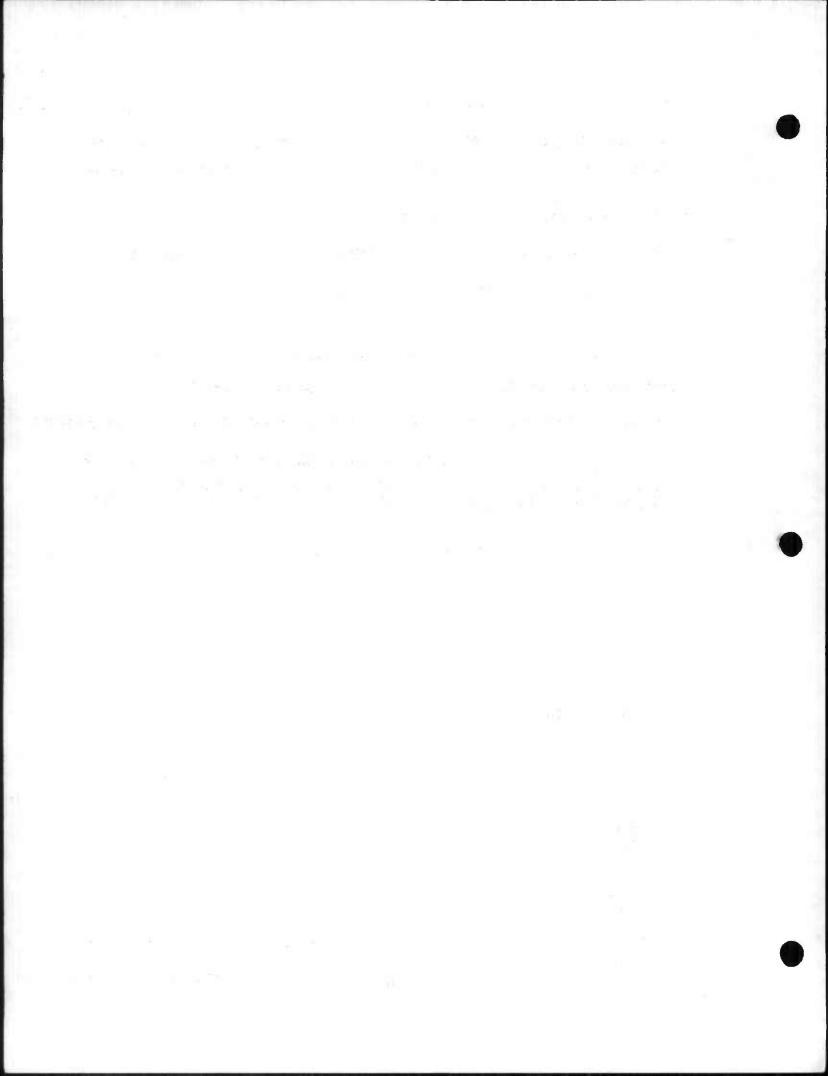
Julia Davidson State Registrar



State of Maryland / Department of Health and Mental Hygiene

14810 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Shahid 00401 Hussain /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL Rockville Montgomery Hours Min. 8. Deta of Birth (Manth, Pay, Year) 5. Social Security Number If Under 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Months Days 11€ M 2□ F 217-25-7061 Pakistan 41 Yrs. Director Usuel Rasidance of Decedant the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumstic event, the Medical Examinal must be notified at Maryland Montgomery Gaithersburg 1 X as 2 □ No Director 10e. Streat and Number 10f. Zip Coda 10g, Citizen of What Country? with 429 Muddy Branch Road 20878 United States nit. Pages 1 and 2 should be filed within 72 hours after death actument of Health end Mental Hygiane.
ortant: If itam 77 is marked other than "natural", or Itema 23.
Injury or other traumatic event, the Medical Examine musis Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? 14. Rece - American Indien, Black, White, atc. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 Navar Married 2 Married I ☐ Yas ZXNo If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 1 Yas 2000 Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Limousine Service Private 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Syed Imteyaz Hussain 2 Surriya Begum 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Steta, Zip Code) Pervaiz Syed (BRotherin law) 9102 Bobwhite Circle Gaithersburg, Maryland 20879 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20e. Mathod of Disposition 20c. Location - City or Town, Stete 1 urial 2 □ Cramation 3 □ Removel from Stata 4 □ Docetion 5 □ Othar (Specify) permit. Page Department Important: If any Injury or Maryland National Memorial Park 4/28/1997 Laurel, Maryland 21. Signat of Funaral Service 22. Nama and Addrass of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 Pent. Entar tha disaasa, or complications in at causad the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heert feilure. List only ona cause on aach lina. Approximata Physician /Medical Immediate Ceusa (Final disaasa or condition rasulting in daath) SEPTIC HRS Examiner Dua to (or as a consequence of) thet the death certificata be executed physician and s the buriel-transit Sequantially list conditions, if eny, laeding to Immadiete cause. Entar Underlying Causa (Disaasa or Injury thet initiated events rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) 80 ed by the ettending a detached for use es Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac PNEUMONIA 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Wes an autopsy performed? 24b. Wera eutopsy findings availabla prior to complation of cause of daath? Completed certificata has 1 Yas 2 NO 1 Yas 2 No Division of Vital Attending Physician: 25. Was casa referred to medical axaminar? 26. Placa of Daath (Check only ona) Hospitel: Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death Certification: 28a. Data of Injury (Month, Dev Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred After Natural 5 Panding Invastigation To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: Afte completely filled in by the fun 1 Yas 2 Accident 6 Could not be datamined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date end place, end dua to tha cause(s) and menner as steted.
2 Medicat Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifian Medical 29b/ Sig sahuni and title of certifier 29c. Licansa number 29d. Dete signed (Month, Day, Year) D 28656 30. Name and refress of person who completed cause of death (Itam 23a) (Type, Print) #464 B SILVER SPRING MSSI 8609 SECOND AVE 31. Date filed (Month, Day, Year) 32. Ragistrar's Signature State whia Davidson-Randall Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Harold O. Hollenberg 28, 4b. City, Town, or Location of Death 1997 11:15 AM 4a. Facility Nema (If not institution, giva street and number) 4c. County of Death Montgomery General Hospital If Under 1 Yaar | If Undar 24 Hrs. Montgomery 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 6 Sax 7. Age (In yrs. last birthday) 15 M 2□ F Months Days Hours Yrs. 315-18-9446 74 March 8,1923 Indiana Usual Rasidance of Decadant 10a. State 10b County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Maryland Montgomery Silver Spring 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 14514 Elmhan Court 20906 U.S.A. 14. Rece - Amarican Indien, Biack, Whita, atc. Was Dacedant Evar in U,S. Armed Forcas? Yas 2 ☐ No Was Decedant of Hispenic Origin? (Specify Yes or No If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 11. Maritel Stetus 1 ☐ Nevar Married 2 Married If Yes, Giva Yaar or Datas: 1 ☐ Yas 2 X No Specify: Specify. 3 Widowad 4 Divorcad WW II White 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Aeronautical Engineer 4 Aeronautics 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Malden Sumama) Martin C. Hollenberg Ida Stamm 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 14514 Elmhan Court Silver Spring, Maryland 20 ace of Disposition (Name of Data 20c. Location - City or Town, State Lillian M. Hollenberg 20906 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematary, cramatory or other plece) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stata 4 □ Donation 5 🖾 Othar (Specifyntombment Gate of Heaven Cemetery 5/01/97Silver Spring, Maryland 21. Signeture of Funarai Sarvica Licensea 22. Nama and Address of Fecility Francis J. Collins Funeral Home, Inc. 23a. Part1. Britar tha disaasa, or complications that bausad the daeth. Do not antar the mode of dying, such as cardiac or respiretory arrast, shock, of haart failura. List only one cause on aach line. 500 University Blvd., W., Sil. Spr., Maryland 20901 Approximeta Intarval Batwean Onsat and Death Immediate Causa (Final disease or condition rasulting in death) acute myocardise infaction Dua to (or as a consequanca of) Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that initiated evants rasulting in deeth) Last Dua to (or as a consequence of): Dua to (or as e consequanca of): Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings aveileble prior to completion of causa of daeth? 24e. Was an autopsy performed? 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No 28. Placa of Death (Chack only ona) Othar: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 1 ☐ Inpatiant 22 ER/Outpetient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury et Work? 5 Panding investigation 1 ☐ Yas 2 ☐ No

The law requires that the deeth certificete be executed Division of Vital Records, P.O. Box 68760, physician the for use es ed by the a signed to page 2 s certificate Hospital or Attending Physician: director, After this funeral di after death.

I Director: Af
d in by the fu death. To the Hospital o within 24 hours aff To the Funerel DI completely filled in

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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or items 23e

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Hygiene.

permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Ilam 27 is marked other any Injury or other traumatic avant

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Certification:

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the Medical Examiner must be notified at

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21215-0020

Baltimore, Maryland

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25. Was casa rafarrad to medical axaminer? 1 Yes 2 No 27. Mannar of Death 1 Natural 2 Accidant 3 Suicida 6 Could not be datarminad 28a. Pleca of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifiar (Check only 29b. Signature and title of certifier 29c. Licansa number 29d. Data signad (Month, Day, Year)

30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

Bernard A. Heckman, M.D. 8830 Cameron Street #405 Silver Spring, Maryland 20910 31. Data filed (Month, Day, Year)

Bo 5373

4-29-97

State Registrar

MAY 01 1997

Benard R. Hecteman, H.D.



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Vaar LACTE ELIZABETH HOLSTON APRIL 29 1997 1400 /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner CHESTERTOWN, MD KENT & QUEEN ANNE'S HOSPITAL 5. Sociel Security Number if Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) **Funeral** Birthplece (State or Foreign Country) 1□M 2☑F Deys 91 Yrs. Director Virginia 579-38-0097 Dec.8, 1905 10e Stete 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at Chestertown MD Kent Director 1X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 21678 25549 Still Pond Neck Rd. U.S.A. Herns 23a Funeral 12. Was Decedent Ever in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, Whita, etc. 1 ☐ Yes 2€ No It Yes, Give Yeer or Dates: 1 Never Married 2 Married 21215-0020 "natural", or 1 Tes 2 No Specify: Black by Specify 3€2Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade com 16b. Kind of Business/Industry completed) Hygiene. Elamantary/Sacondary (0-12) 7th College (1-4or 5+) Housewife None Baltimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maidan Sumeme) Be permit. Peges 1 end 2 should be to Department of Health end Mental Important: If Item 27 is marked of any Injury or other traumatic eve Haywood Ralls Elizabeth ? 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Steta, Zip Code) 7805 Jeremy Terrace, Derwood, MD 20855 James E. Holston (Son) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 5/5/97 Rockville, MD Parklawn Mem. Park 4 ☐ Donetion 5 ☐ Other (Specify) 21-Signature of Funeral Service Licensee 22. Name end Address of Facility
SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD Pert1. Enter the dillesse, or complications that caused the deeth. Do not enter the mode of dyling, such as cerdiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediete Ceusa (Final disease or condition resulting In daeth) Examiner Examine Metostatic Brondwceuse

Due to (or es e consequence ot): The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest the buriel-trar P.O. Box 68760, Physician/Medical Due to (or es e consequence ot): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 DNo 3 Probably 4 Unknown Hypentensin, Cartestes, Chalcuptectory, Records, Be Completed by E KRON director, page 2 should be 24a. Was an eutopsy performed? 24b. Wara autopsy tindings eveileble prior to completion of cause of daath? ASCUD, Contro tes, Hypexia, o couet Gasto intestino Bluding with Anemia Clausowa (enkocy faze's 1 Yes

25. Was casa referred to madicel exeminar?

Hospital certificate 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Hospitel: 1 Inpatient 2 ER/Outpetlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 ₹No s efter oc... ral Director: After ry the funeral di 28c. tnjury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Panding Investigation 1 Neturel vone 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Ptace of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours ele Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, daath occurred et the time, data and place, end due to the ceuse(s) end menner stated. 29e. Certifier To the Hosp within 24 hou To the Fune completely fi 29b. Signature and title of certitier 29c. License number 30. Neme end address of person who completed ceuse of daath (ttam 23e) (Type, Print) 31. Data tiled (Month, Day, Year)

32. Religior's Storature

32. Religior's Storature

34. O 2 1997 State MAY 0 2 1997 Registrar

State of Maryland / Department of Health and Mental Hygiene

					,	Certifica	ate of	Death		Reg. No.	9/	14813			
	, , , , , , , , , , , , , , , , , , ,		1. Decedant's Nama (First, Middla, La	est)					2. Data of Dec	ath	Yaar	3. Tima of Death			
	Physic /Medi		Laura H.	Hull					Mav	O.3	1997	10:55 AM			
)	Exami		4a. Facility Nama (If not institution, gi	va street and number;			-	4b. City, Town, or L		4c. Co	ounty of Death				
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	Funeral Director			Sax 7. Ag 1 M 2 F	75 pa (In yrs. I	Ast birthday) If Und Month	dar 1 Yaar is Days	If Undar 24 Hrs. Hours Min.	8. Data of Birt (Month, Da May 9,	y, Year)		nplaca (State or Foreign intry) nsylvania			
	hend wo		10a. Stata 10b. County		10c. City	, Town or Location						10d. Insida City Limits			
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	th with the Maryler 23s or 28s-f show	Funeral Director	10e. Street and Number				Zip Coda			10g. Citizen	of What Cou	intry?			
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	Hems Nec.	Iner	11. Marital Status	12. Was Decedant Armed Forcas	Evar in U.	S. 13. Was Dec	cedant of H	lispanic Origin? (Sp an, Maxican, Puarto			Race - Amari Black, White	ican Indian,			
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2		ပိ	unknown 17. Fathar's Nama (First, Middla, Las			Sewing Ma	achin	e Operato 18. Mother's Nam			ting M	<u>ill</u>			
Maryland	s 1 and 2 should be filed with F Health end Mental Hygiene. fem 27 is marked other than other traumatic event, the Mental traumatic event, the Mental Exercises.	Be		,						Majuari Sui	marria)				
2	2 should be f end Mental I e marked of aumatic eve	2	Hiram Hull 19a. Informant's Name/Raiationship	(Type Print)		19h Mailing Addrs	ses (Stroat	Mamie W and Number or Ru		ar City or Tr	num State Z	in Code)			
M			Ruth Jefferies /		ator							p 0000)			
e,	f Head		20a. Mathod of Disposition	beep dadgi	20b. Pi	P. O. Box ace of Disposition (A ematary, crematory of	vama of		Data PID		ion - City or T	own, Stata			
Ë	Pege at: If i		1 ☑ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			iking Spri			May 7 1997	Sink	ing Spr sylvan	ring			
Baltimore,	permit. Peges 1 and 2 Department of Health e Important: If item 27 if eny Injury or other tra once.		21. Signature & Funeral Service Little	La											
m	Depariment of the part of the		22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MI												
			23a. Part1. Enter the disease, or con	plications that cause	tha daath	. Do not antar tha m	oda of dyir	ng, such as cardiac	or raspiratory ar	rrest,	SL MD	Approximata			
я	Physician		23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death												
4	/Medical		Immediata Causa (Final disassa or condition Lung Cancer with M. tastalls 2 Manths												
п	Examiner		rasulting in death)	a.		as a consequanca o		(1-21-011)				0 , 00 , 1,			
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	death certificate be executed attending physician and of for use as the burial-transit	Examiner	Sequentially list conditions,	D.	Dua to (or	as a consequance o	t):								
68760,	be exictan buria	aiE	Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseasa or Injury	c							i				
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Box	certifi nding use a:	N.		d							- !				
B	s atte	icia	Part II. Other significant conditions	contribution to death h	ut not recu	Man in the contest in		on in Don't	nah Did 6	labassa us	o o o o o o o o o o o o o o o o o o o	to the cause of death?			
0	that the death cered by the attendir detached for use	hys	Tarti. Other arginicant conditione	contributing to death b	ot not rasu	nuing in the uncertying	g causa giv	an in Fanti.	1/104	Y 00 2 1		obably 4 Unknown			
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of V		ပို	1 Yas 2 No	Hospital: 1 Inpatia	ant 2 🗆 I	ER/Outpatient 3□	DOA Oth	ar: 4 Nursing H	oma 5 🗆 Rasio	dance 8	Other (Spec	ity)			
n n	Attending Ph or death. ector: After thi by the funeral		27. Manner of Death 1 ☑ Natural 5 ☑ Panding	28a. Data ot Inju (Month, Da	y Year)	28b. Tima of Injury	28c. Injur Wor	y at k?	28d. Dascribe	how injury o	ccurred				
sio	Attending r death. ector: After by the fune	cati	2 Accident Invastigation 3 Suicide 8 Could not be			М	10	Yas 2 □ No							
Division	8445	Certification:	4 Homicida datarmined	28a. Piace of In building, at	ury - At ho c. <i>(Specify</i>	ma, farm, street, tact)	ory, office		28f. Location (S City or Tox		lumber or Rui	ral Routa Number,			
В			29a, Certifier 1/D Certifying Pr	vericles. To the best	at mu langu	deden death accuse	and and the a time	data and -1	and due to the						
	To the Hospital within 24 hours To the Funeral completely filled	edicai	(Check only one) 2 Medical Exam	nyaician: To the best miner: On the basis o and mannar st	axaminat	on and/or invastigati	on, in my o	pinion, daath occur	red at the time,	data and pla	aca, end dua	to the cause(s)			
	Vithin To the	Me										, Day, Year)			
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	6		30. Nama and addrass of person who	complated causa of o	laath (Itam	23a) (Type, Print)	D.	ا ا داود		J- 3	27)				
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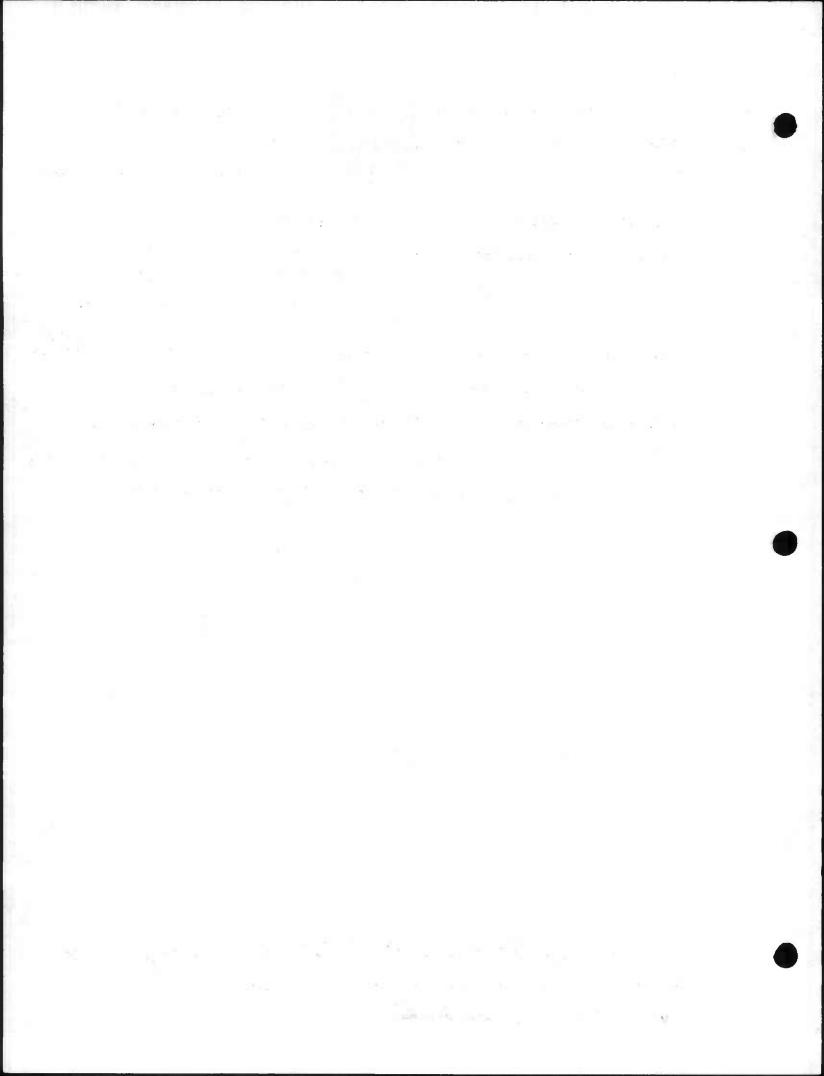
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State of Maryland / Department of Health and Mental Hygiene

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	LAGIIII	iici	Medpointe Continu	ing Care F	acility			E1:	kton			Ceci				
	Funeral		5. Social Security Number 6. S		(In yrs. last birtho	lay) If Undar 1		If Undar		8. Data of Bi	irth					
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	dend w		10a. Stata 10b. County		10c. City, Town o	r Location						T	10d. Inside City Limits			
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	A S	급	10e. Street and Number	onto Ant	N - 11	10f. Zip 0	Coda	210	0.2		10g. Citizan of What Country? U.S.A.					
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020	ges 1 and 2 should be filed within 72 hours efter deeth with the Maryland it of Heelth end Mental Hygiene. If frem 27 is marked other than "naturet", or items 23a or 28a-f show or other treumatic event, it a Medical Examiner must be notified at	by	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant E Armed Forcas? 1 ☐ Yas XX N If Yas, Giva Yaar or Datas:	o lo	13. Was Deceda If Yas, specif			gin? (Spe i, Puarto	Porty Yas of N Rican, atc.)	o- 14. Ha Ble Speci	ack, Whita	ican Indian, , atc. White			
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ary	should No hand	-	19a. tnformant's Name/Raletionship (Type, Print)	19b. N	elling Address (Street				ber, City or Town	n, Stata, Zi	p Code)			
	Heelth e Heelth e em 27 le		Linda Holman (Dau	ghter)							n, Maryl					
e,	f Her frem othe		20a. Mathod of Disposition		20b. Placa of D		a of			Date	20c. Location					
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alti	permit. Per Depertment Important: any injury		4 Donation 5 Other (Specify) Hopewell Cemetery 5/5/97 Port Deposit													
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90,	certificate be executed ording physician and use as the burial-transit		Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants	· Das	as a consequence of.							i				
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Sic	Attending r death.	cat	2 Accident invastigation 3 Suicide 6 Could not be			М		Yas 2								
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			Decition of	(Ocela	un m	0 7	7):	379	16		Man	3	1997			
	2		30. Nama and address of person who		k	pe, Print)		- / /	70		(-/-				
			Cecilia B. Caldern, M.D., 223 West Main Street, Elkton, Maryland 21921													
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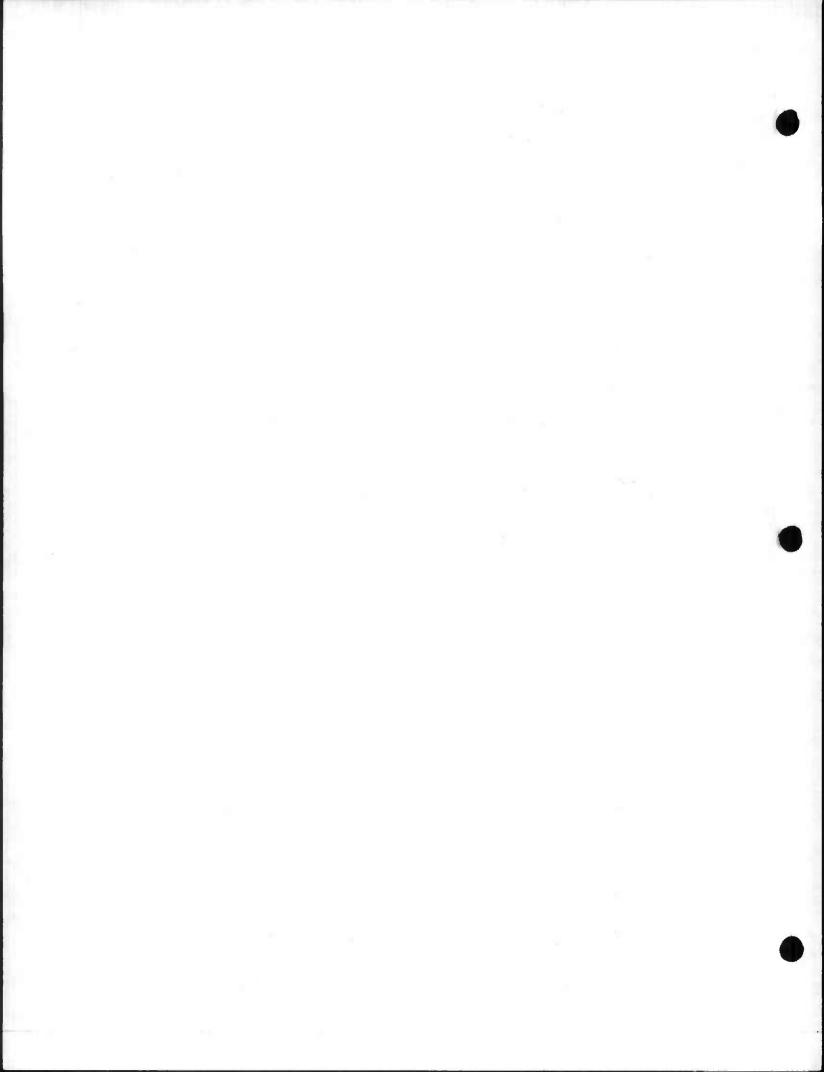
State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Kathy Lynn Harford 29, April 1997 1:30 PM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 18726 Brick Store Road Hampstead Baltimore If Undar 24 Hrs. Hours Min. 5. Social Sacurity Number If Under 1 Year 8. Date of Birth (Month, Day, Year) Feb 17,1952 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** Days 1 M 2 BF **Yrs** Director 45 546-84-7019 California Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health end Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show items 23a or 28a-f show incr must be notified at Director 1 Yes 2√ No Maryland Baltimore Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18726 Brick Store Road 21074 Funeral USA 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status the Medical Examiner 1 Never Married 2 Married 21215-0020 ŏ 1□ Yes 2□No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Whiting & Turner 4 traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Be Depertment of Health end Mental Important: If Item 27 is marked or any Injury or other traumatic eve 0 John Henry Kirkpatrick Hopi Karich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) Richard D. Harford, Husband 18726 Brick Store Rd, Hampstead, MD 21074 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/3/97 Hampstead Cemetery Hampstead, MD 22. Name and Address of Facility 21. Signature of Fugeral Service Licensee Eline Funeral Home CLA 934 South Main St, Hampstead, Md 21074 23a. Part1. Enter the disaasa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each lina. Approximata Interval Between Onset end Death **Physician** /Medicai Immediate Cause (Final patic cier mais He diseasa or condition resulting in death) Examiner Due to (or as a consequence of): Examiner plail or Attanding Physician: The law requires that the deeth certificate be executed ours after death.

The set of the certificate has been signed by the ettending physician and filled in by the increat director, page 2 should be detached for use as the buriat-transit filled in by the functal director, page 2 should be detached for use as the buriat-transit. Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2. ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of ceuse of death? 1 Yes 2 No 1 Yes 2 No Be 25. Was cese rafarred to medicel 26. Place of Death (Check only ona) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 Yes 2 →No 1 Inpatient 2 ER/Outpatlent 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 5 Panding Investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di completely filled in Medicai Certifying Phyatcian: To the best of my knowledga, death occurred at tha time, date and placa, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and 29c. License number of portifier 29d. Date signed (Month, Day, Year) 30 D33165 8 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) Steven Shaffer M.D., 2111 Hanover Pike, Hampstead, MD 21074 31. Date filed (Month, Day, Year) MAY 02 32 Registrar's Signature State 02 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item # 7 per FD 5/5/97 Certificate of Death County RG
1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month May Olay 10:25 PM Beverly Sue Hagan /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 6406 White Rock Rd. Sykesville Carroll If Under 1 Yeer If Under 24 Hrs.
Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Monty, Day, Year) 9. Birthplece (State or Foreign **Funeral** 1 M 2 KF 549-96-4598 44 Yrs Director California Sept. 9, 1952 Usual Residence of Decedent tha Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner naun be notified at 1 Yes 2X No Director Maryland Carroll Sykesville 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 items 23a 6406 White Rock Rd. 21784 United States death Funeral 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural". or in-any injury or other traumatic events once. Bleck. White, etc. 1 ☐ Never Married 2 Merried 1 ⊠Yes 2 □ No 3/4/75 If Yes, Give Yeer or Dates: to 7/3/78 Specify: White 1 ☐ Yes 2 🕱 No þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4years Elementery/Secondary (0-12) DOD Analyst Department of Defense 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be William H. Hagan 2 Beulah I. Toline 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert Mayne (Husband) 6406 White Rock Rd. Sykesville, MD 21784 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ₺ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) May 3, 1997 Sykesville, MD Springfield Cemetery 22. Name end Address of Fecility Burrier-Queen Funeral Directors 21. Signeture of Funeral Service Licensee 1212 W. Old Liberty Rd. Winfield, MD 21784 23e. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Respiratory Failure Examiner Due to (or es e consequence of): Physician/Medical Examiner Asperation Promonio attending physician and for use as the burial-transit that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest P.O. Box 68760. Concer-me tos to tic-Ovarina Due to (or as e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. been signed by the a should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown GI obstruction Records, Completed by The law requires 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evallable prior to completion of ceuse of deeth? Pancy topenia, Anorgra- Unchixic paga 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata of Vital spital or Attending Physician: The hours after death.
Ineral Director: After this certificate y filled in by the funeral director, pa Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homleide To the Hospital
within 24 hours a
To the Funeral C
completaly filled Hospitai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) and menner stated. Medical 29a. Certifier

State Registrar

31. Dete filed (Month, Day, Year)

9/Hid

MAY 02 1997

29b. Signeture end title of certifier

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Baturent Parkway 32. Registrer's Signeture

Juli Sweden Redall

MO

29c. License number

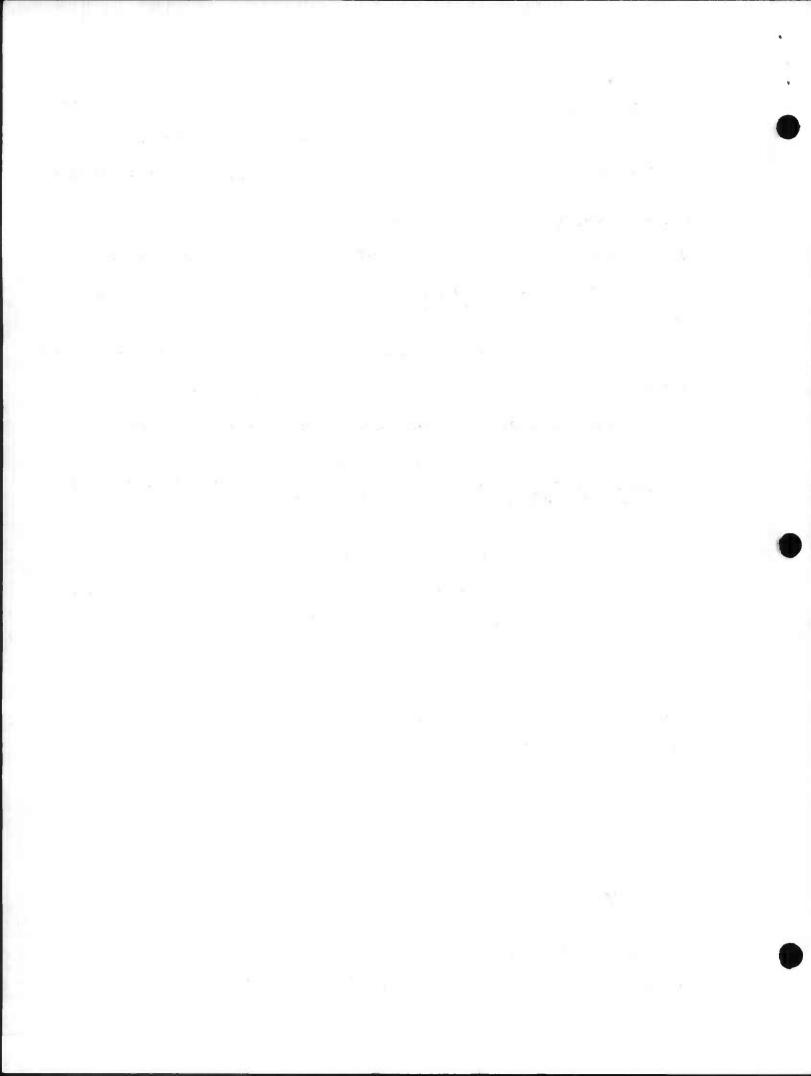
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Columbia

29d. Dete signed (Month, Day, Year)

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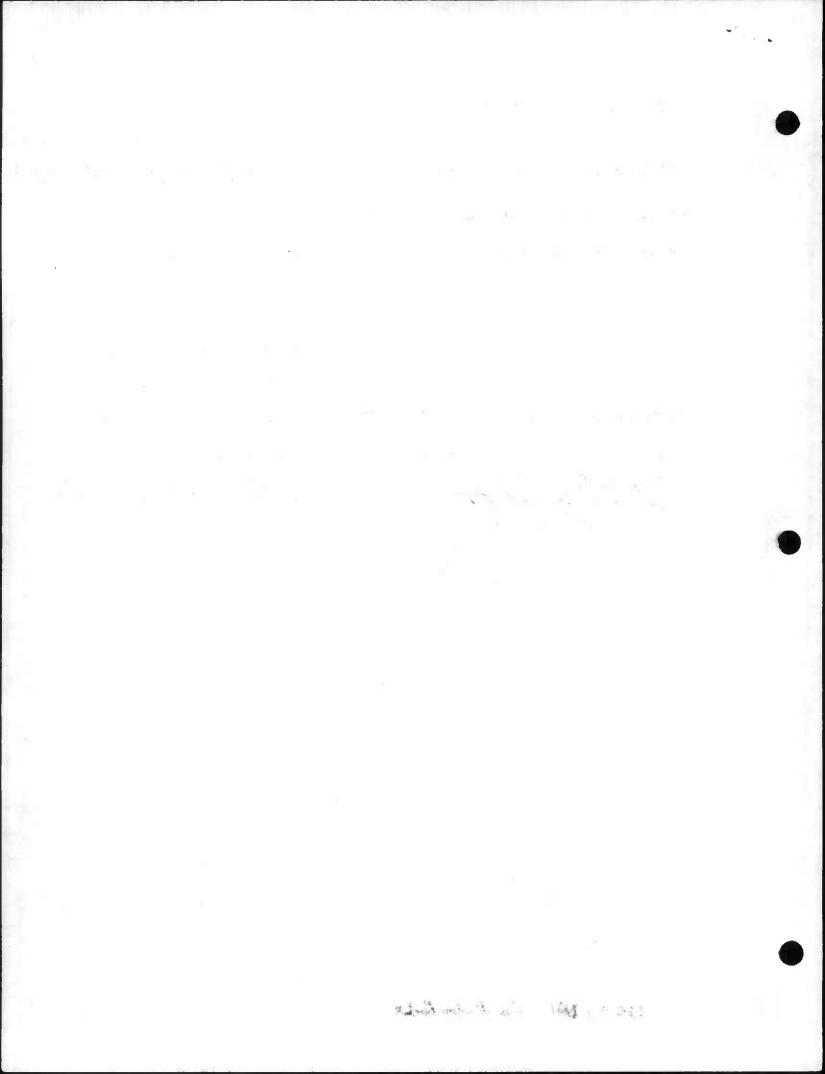
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State of Maryland / Department of Health and Mental Hygiene 97 11817

			Certifi	cate of	Death		Reg. No.	1	14017		
Dhucialan	1. Decedent's Name (First, Middle, Lat					2. Date of Dea	1117	Year	3. Time of Death		
Physician /Medicai	VENIE	HARPER			ELL I	ADY	27	97	6.18		
Examiner	4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or I	ocation of Death	,				
	PRINCE GEO	DRGE HOSPI		ENTRE				NCE	CHEORGE		
uneral rector		7. Age (In yrs. I	. Mo	Under 1 Year onths Days		8. Date of Birth (Month, Day August		9. Birthple Count 25 V	ace (State or Foreign ^{ry)} Fluvann irginia		
and an	Usual Residence of Decedent 10a. State 10b. County	10c, City	, Town or Locatio	n			10d. Inside City Limits				
otor	M - 1 7 7 7	ce George	Bladens						Y Yes 2 No		
event, the Medical Examiner must be incliffed at BE Completed by Funeral Director	10e. Street and Number 6011 Emerson	Street	10	Of. Zip Code	20710		10g. Citizen of V	What Count	ny?		
Examiner in by Fune	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 □ Yes 2 ☑ No If Yes, Giva Year or Dates:	If Yes	Decedent of s, specify Cut res 2 No	of Hispanic Origin? (Specify Yes or Juban, Mexican, Puerto Rican, etc.) No Specify:		or No- c.) 14. Race - Am Black, Wh Specify: B		otc.		
Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent's (Give kind life. DO N	Usual Occu of work done OT use retire	during most of wor.	king	16b. Kind of B	usiness/Ind	ustry		
E O	Elementary/Secondary (0-12)	Collage (1-4or 5+)	Admini	istra	tive Ass	istant	Gove	rnme	nt		
Be C	17. Father's Nama (First, Middle, Last)				18. Mother's Nan		Maiden Suman	10)			
To E	Robert	Whit	e		Estell	a	D	abbn	еу		
T	19a. Informant's Name/Ralationship (7 Carolyn Harper				ell Dr.(
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specify	Removal from State	lace of Disposition emetery, cremator	y or other pla	ial Cem.	Date 5-1-97	20c. Location -				
4	21. Signature of Funeral Service Licen										
8 8	- X	11			nning Ro	rdan F	uneral (Wash	Ser	vice, Inc.		
an al er	23a. Part L Entar the disease or comp shock, or heart failure List only i Immediata Cause (Final disease or condition resulting In death)	a. SEF							interval Between Onset and Death		
in a		, INFARTED	BO	WE	_						
cian/Medical Examiner	Sequantially list conditions, if any, leading to immediate	Dua to (or	as a consequanc								
<u>@</u>	Causa (Disaase or injury	. DIABETE									
Medical	that Initiated events resulting In daath) Last	,	as a consequence	•		- 0 .	-				
an/M		d_ RENAL	FAIL	LURE	,	STROK	6				
y Physician	Part II. Other algnificant conditions co	ontributing to death but not resu	Iting In the underly	/Ing ceuse gi	ivan in Part I.				the cause of death?		
-	HYPERT	ENSION				1 D Y	es 2 No	3 Probi	ably 4 Unknown		
page 2 should be Completed by						24a. Was a perfor		avai	re autopsy findings ilable prior to apletion of cause eath?		
Comp						1 🗆 Y	es 21 No		Yes 200No		
orrector, p	25. Was cesa raterred to medicel				26. Place of Dea				. 30		
	examiner? 1 ☐ Yes 2 ☐XNo	Hospital: 1 [XInpatient 2]	ER/Outpatiant 3[DOA OI	har:	ome 5 Resid		er (Specify)			
	27. Manner of Death 1 Danatural 5 Pending 2 Accident Investigation	(Month, Day Year)	28b. Tima of Injury	28c. Inju Wo		28d. Describe h	_				
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, fa	actory, office		28f. Location (S City of Town		er or Rural	Route Number,		
Medical Certifi	29a. Certifler 1 Certifying Phy (Check only one)	rsician: To the best of my know iner: On the basis of examination and manner stated.	rledga, death occu on and/or investig	irred at the ti ation, in my	me, date and place, opinion, death occur	and due to the c red at tha time, d	euse(s) and ma late and place, (nner as sta and due to t	ited. the ceuse(s)		
¥ €	29b. Signature and title of certifier			29c. Licen:	se number	2	9d. Date signed	d (Month, D	ay, Year)		
-	Banel			DO	050 99	51	4/2	719	7		
)	30. Name and addrass of person who c	ompleted ceuse of death (Itam	23a) (Type Print)	_			100	, (
//		LL 6510	KENI	200	RIM A	DENUE	= #2	400	RIVERDAL		

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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						Cei	tificate	of L	Death		Reg.	No.			
	Physic /Medi		Decedent's Name (First, Middle, La RUB	S			2. Date Mon	of Deeth	Deeth Dey Yeer - 28 - 9		3. Time of Death				
	Exami		4e. Fecility Neme (If not Institution, give					4		or Location of		4c. County	of Deeth		
	Funeral				Age (in yrs. las			eys	If Under 24	Sprin Hrs. 8. Dete Min. (Mon	of Birth th, Dey, Ye	er)	9. Birthpli Count	y lece (Stete or Foreign try)	
	Director		253-22-6900 Usuei Residence of Decedent		82	Yrs.				Apr:	1 21	, 191	5 Ge	orgia	
	with the Maryland a or 28a-f show be notified at	tor	10a. Stete 10b. County District of C	olumbia		Town or Lo ashin							10	0d. tnside City Limits 1√2 Yes 2 □ No	
	th the	Director	10e. Street and Number			4011211	10f. Zip Co	de			10g.	Citizen of	What Count	lry?	
	23a c	ai	342 Eastern Ave	nue, N. H	Ξ.		200	019			Uı	nited	State	es	
020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-f show thy the Medical Examiner must be notified at	by Funeral	11. Meritei Stetus 1 □ Never Merried 2 □ Married 3 □ Widowed 4 □ Divorced	12. Wes Decede Armed Force 1 Yes 21 If Yes, Give Yeer or Dete	s? No		Wes Decedent f Yes, specify 1 ☐ Yes 20		spanic Origin n, Mexican, P Specify:	? (Specify Yes uerto Rican, et	or No- c.)	Specify	ce - America ck, White, e	etc.	
0-0	n 72 hours "netural",		15. Decedent'e E	ducation		16a. Deced	ient's Usuai O	ccupe	etion		166		1Can Ausiness/ind	American	
1215	within 7 ane. then "n	Completed	(Specify only highest gri	College (1-4d	or 5+)	`life. I	kind of work of DO NOT use r	etired)	working					
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Maryland 21215-0020	s i end 2 should be filed within 72 ho Health and Mentel hygiene. tem 27 is marked other than "netur other traumatic event, the Medical	To Be	John B. Hollowa							Keith					
Mai	d 2 st h and h and r la m		19e. informent's Name/Reletionship (,, .,						r Rural Route i					
	1 end 3 Health em 27 l		Patricia H. Willi 20e. Method of Disposition	ams - Ni		840 2 ce of Dispo	1st St sition (Name	ree	et, N.	E., Was	hingt	on, D.	C. City or Tov	20002	
Baltimore,	00-		1 Burial 2 □ Cremetion 3 □		te cen	netery, cren	netory or othe	r plec	,						
Balt	permit. Peg Department Important: It any Injury o		4 Donetion 5 Dother (Specify) Harmony Memorial Park 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility STEWART FUNERAL HOME, Inc.												
			23a, Park, Enter the disease, or com	Dicetions that caus	sed the deeth.	Do not ent	001 Be	nni	ing Roa	d, N,E	. , Was	hingt		Approximete	
Ý	Physician /Medical		Enter the disease, or combined, or heert tellure. List only		EPS			,			iony omoon		1	Interval Between Onset and Death 2 WEEKS	
	Examiner	Je.	disease or condition resulting in deeth)	0. 7	Due to (or a		uenca of):							ZNIERS	
	nsit	Examiner		b. N	EUNI	UN	14								
Ö,	e exectian and		Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury	,	Due to (or e	is e conseq	uence of):								
x 68760,	certificate be executed iding physician and ise es the buriel-transit	/Medical											i		
Bo	- 63	Physician	Pert fi. Other significant conditions of	ontributing to death	n but not resulti	na in the ur	nderlving caus	e give	en in Pert I.	23b	. Did tobe	cco use co	ntribute to	the cause of death?	
P.0	thet the dead by the detached		RECTAL	BLEE	DING	, C4	RISE	N	DETERM	(181)	1 🗆 Yes		3 Prob		
of Vital Records,	v requires that the deeth been signed by the atter ahould be detached for	ted by	DEMENTIN	1.						24a.	Wes en a	utopsy 1?	eva	are autopsy findings	
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a	ician: The li certificate ha rector, page										1 🗆 Yes	2)8UNO	10	Yes 2 No	
<u> </u>	Physician: this certificanal director,	o Be	25. Wes case referred to medical examiner?	Hospitel:				Othe	DF: .	Death (Check					
		 -	1 ☐ Yes 2 ☑ No 27. Menner of Deeth	1 ☐ inpe		VOutpetien 8b. Time of			AME) Nursir	ng Home 5 ☐ 28d. Des		e 6 ∐Oth njury occur)	
ion	Attending In death.	ation	1 Seturei 5 Pending Investigation	(Month, I	Dey Year)	Injury	М	injury Work	res 2 □ No			,,			
Division	= 5 th 6	Certification:	2 Accident 3 Sulcide 4 Homicide 28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or R City or Town, Stete)									er or Rural	Route Number,		
	the Hospital or thin 24 hours after the Funeral Dir mpletely filled in	edicai C	29e. Certifler (Check only one) 15/ Certifying Ph	ystclan: To the bas ntner: On the basis end menner	of examinetion	edge, deeth n end/or inv	occurred et the estigetion, in	ne tim	e, dete end p pinlon, deeth o	lece, end due t	o the cause time, dele	e(s) and me end piece,	and due to	ated. the cause(s)	
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	(2)		30. Name and eddress of person who	completed cause o	deeth (Item 2	3a) (Type, 1	Print) 8 GE	OP	41A F	NF. IN	1770	N, M	D 2	10906	
	Sta Registr		31. Dete filed (Month, Dey, Year) APR 3 0 199	7 32 Regis	strar's Signetur	Robert	}		-, -,	,		1			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month 3:30 pm Virgie Ellen Hicks 1997 April 28, /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Springbrook Adventist Nursing Center Silver Spring Montgomery If Undar 1 Year 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) Months Deys Hours 1□ M 2፟ F 578-36-2301 95 Yrs 24, 1901 Washington, D.C. Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d, Inside City Limits Maryland Montgomery Director Silver Spring 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12325 New Hampshire Avenue 20904 U.S.A. Funeral 12. Wes Decedent Ever In U.S. Armed Forces? Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, atc. 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Naver Married 2 ☐ Married 1 ☐ Yes 2 ☒ No Specify: P A Specify: 3 ™ Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest g completed) Elemantary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 6 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Maldan Sumama) Be Charles O'Niell Annie Becker 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Virginia H. Perholtz - Daughter 7506 Edmonston Road, College Park, Maryland 20740 20b. Pleca of Disposition (Name of camatery, crematory or othar place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Ramovel from Steta 5/2/97 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery Suitland, Maryland 22. Name end Address of Facility
Francis Gasch's Sons Funeral Home, P.A. 21 Signeture of Funeral Sarvice Licenses Jas 4739 Baltimore Avenue, Hyattsville, MD 20781 nolance 23e. Pert1. Enter the disease, or complications that caused tha death. Do not anter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on sech line. Immediete Ceuse (Finel diseese or condition resulting in deeth) Due to (or es e consequence of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequenca of): Physician/Medical Due to (or as a consequenca of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ Be Completed 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 2 K N 1 ☐ Yes 2 No 25. Wes case referred to medical examiner? 28. Plece of Deeth (Check only one) Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2⊠ No 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menper of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 29e. Certifian 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of cortifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Dr. Michael E. Leibowitz 11120 New Hampshire Avenue #305, Silver Spring, MD 20904 31. Dete filed (Month, Day, Yeer)

State Registrar

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Madical Examinat must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Introcrant: If Itam 27 is marked other than "natural", or iten any injury or other traumatic avant.

Physician /Medical

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certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funaral director;

page 2

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The law requires that the deeth certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Baltimore, Maryland 21215-0020

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32, Registrar's Signeture A. Atualog A State of Maryland / Department of Health and Mental Hygiene

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					Cer	titicate of	Death		Reg. No.				
	,	1. Decedent's Nama (First, Middla, La	st)					2. Data of D	eeth	Verr	3. Time of Deeth		
Physic /Med		MARY	HALL					APRIL	26. 1	Yaar 997	7:40AM		
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Director		213-66-3518	□ M 2∏ F	42	Yrs.	MONTHS Deys	nours	MAY 2	0,1954	CALF	ORNTA		
р,		Usuel Residence of Decedent							,				
anyla	-	10a. State 10b. County		10c. City, To	own or Loc	cation				10	d. inside City Limits		
M Page	cto		GEORGE	MT.	RAIN	IIER					1. Yes 2□ No		
or 2	Director	10e. Straet end Number				10f. Zip Code			10g. Citizen of	Whet Count	ry?		
ath with the Marylan 23a or 28a-f ahow		3364 CHILLUM R	OAD			20	712			USA			
Items Instrument	Funeral	11. Maritel Status	12. Wes Decedent I Armed Forces?		13. W	les Dacedant of H Yes, specify Cub	lispanic Origir an, Mexican, I	n? (Specify Yes or Ni Puarto Ricen, etc.)	0- 14. Red Ble	ca - Amarice ck, White, e			
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Baltin permit. Pe Departmen Important: any injury		21. Signetura of Funeral Sarvice Licer		GEUK				4/26/97		NGTON	, D.C.		
Ba Depa Impo any i		22. Name and Address of Facility AUSTIN ROYSTER FUNERAL HOME 3821 14TH ST. N.W., WASHINGTON,											
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P.O.	h	Thousand	un abusa						Yes Zino		ably 4 Unknow		
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Division of Vital Record or Attending Physician: The law require effer death. Director: After this certificate has been side by the funeral director, page 2 should I in by the funeral director, page 2 should I	BeC	25. We case referred to medical		+	•		26 Place of	f Deeth (Check only	A	1	145 2010		
Vision of Vita Attending Physician: or death. ector: After this certific by the funeral director,	To B	exeminar? 1 ☐ Yas 2 ☑ No	Hospital:	nt 2□ER/	Outnetlent	3□ DOA Oth	ner:	Ing Homa 5 ☐ Resi		or (Enacibe			
Phys Pritis eral di		27. Manner of Deeth	28e. Dete of injur	v 28t	. Tima of	28c. Injur	A		how injury occur				
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D PER P	Certification:	4 LI Homicide	building, etc	:. (Specify)				City or 10	wn, Stata)				
Division of Vital Re- To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	- 1	29e. Cartifler 1 Certifying Ph	sician: To the best o	f my knowled	ga, daath	occurred et tha tir	na, data and p	plece, end due to the	cause(s) and me	annar as sta	ited.		
he He in 24 he Fu	edical	(Check only one) 2 Medical Exam	iner: On the basis of end manner ste	examination ted.	end/or inve	estigetion, in my o	pinion, deeth	occurred et tha tima,	data and place,	and due to	the cause(s)		
To the Com	Σ	29b. Signeture and title of certiful	1,	^		29c. Licens	a number		29d. Data signe	d (Month, D	Pay, Year)		
		Lowest	WW N	U)		1)42	403 (mazylary)	4/2	8/47			
		30. Neme and address of person who	completed cause of de	eth (itam 23a	a) (Type, P	rint)		V /	1	-/ (/			
		RAJ MATHU	R, MD.	110 II	RVIN	G STRE	ET N.	W., WASH,	DC.				
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MANA TO THE THE PART

Please Type or Print in Black Indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth . Dey 1997 April 28, 11:07 PM DOMENICO IENZI 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 0ct. 2, 1912 5. Sociel Security Number 9. Birthpiece (State or Foreign Country)
Italy 6. Sex 7. Age (In yrs. lest birthdey) 1₩ M 2□ F 84 Yrs. 579-54-5691 Usual Residence of Deceden 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Maryland Prince Georges Hyattsville 10e, Street end Number 10f. Zip Code 10g. Citizen of What Country? 7105 24th Place 20783 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Merried 2 Married 1 ☐ Yes 2 🖫 No Specify: Specify. 3 Widowed 4 □ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Self-employed Barber 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Domenico Ienzi Teresina Apifenia 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Alberto Ienzi / Son 1 Bryants Nursery Road, Silver Spring, Maryland 20905 20b. Pieca of Disposition (Name of cemetery, cremetory or other plece) 20a, Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriei 2 ☐ Cremation 3 ☐ Removel from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 5/2/97 Signature of Funerei Servica Li 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervei Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction 30 minutes Due to (or es e consequença of): Ischemic Heart Disease 15 years Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Emphysema 24b. Were autopsy findings aveilable prior to 24e. Wes en eutopsy completion of cause of deeth? 1 ☐ Yes 2 No 1 Yes 2 No 26. Piece of Deeth (Check only one)

Physician /Medical Examiner

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yd bengis

certificate

this

After

death.

Do: 0000

Box 68760

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Records.

Division of Vital Hospital or Attending Physician: **Physician**

/Medical

Examiner

Funerai

Director

r than "naturel", or items 23a or 28a-f show the Medical Exemper must be notified at

or items

Director

by

Completed

the Maryland

hours after

2 should be fi and Mentai H is marked of

permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic av-

Baltimore, Maryland 21215-0020

2 8 To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f

Physician/Medical by Completed Be 2 Certification: edical

25. Wes case referred to medical exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. Injury et Work? 27. Menner of Death 28a. Dete of injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Naturei Injury 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homleide 29a. Certifier

(Check only

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner es steted.

| Medical Exeminer: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier 2 y g md. 29c. License number 0 23630 29d. Date signed (Month, Dey, Year) April 29, 1997

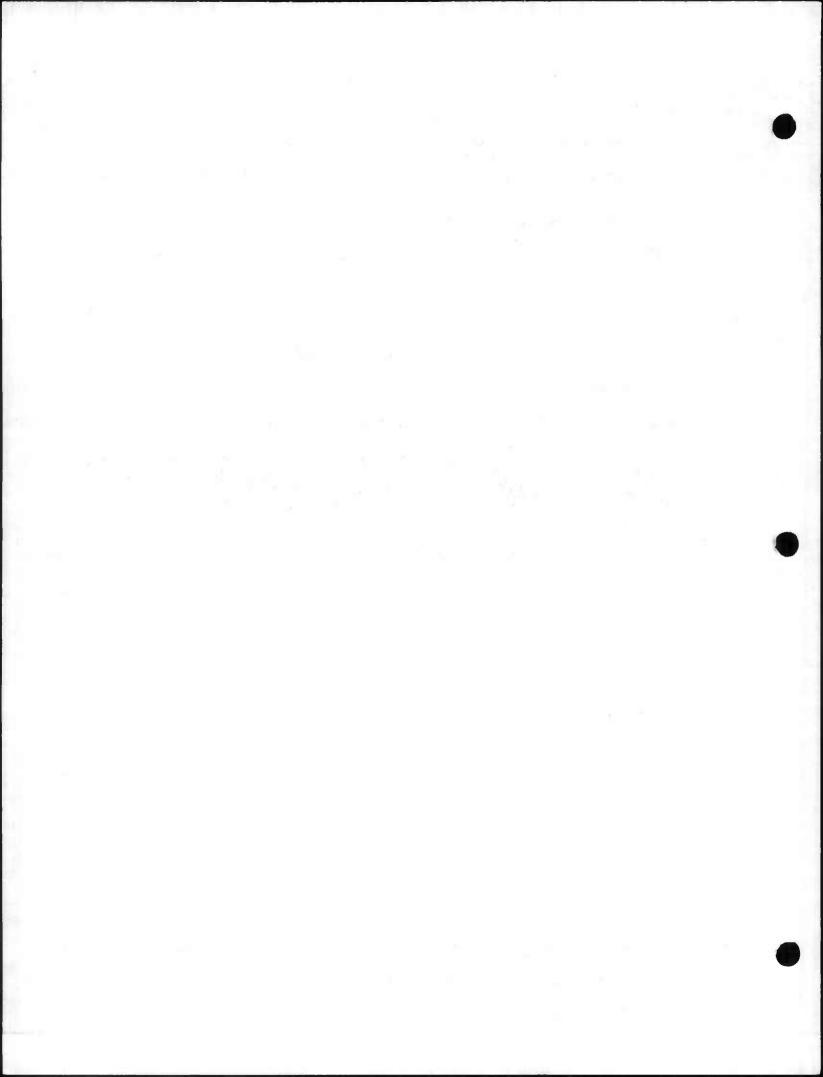
30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

16220 FREDERICK RO #213, Gaithersburg, MOZUETT FRANK J. MAYU, MO 31. Dete filed (Month, Dey, Year) MAY 01 1897

State Registrar

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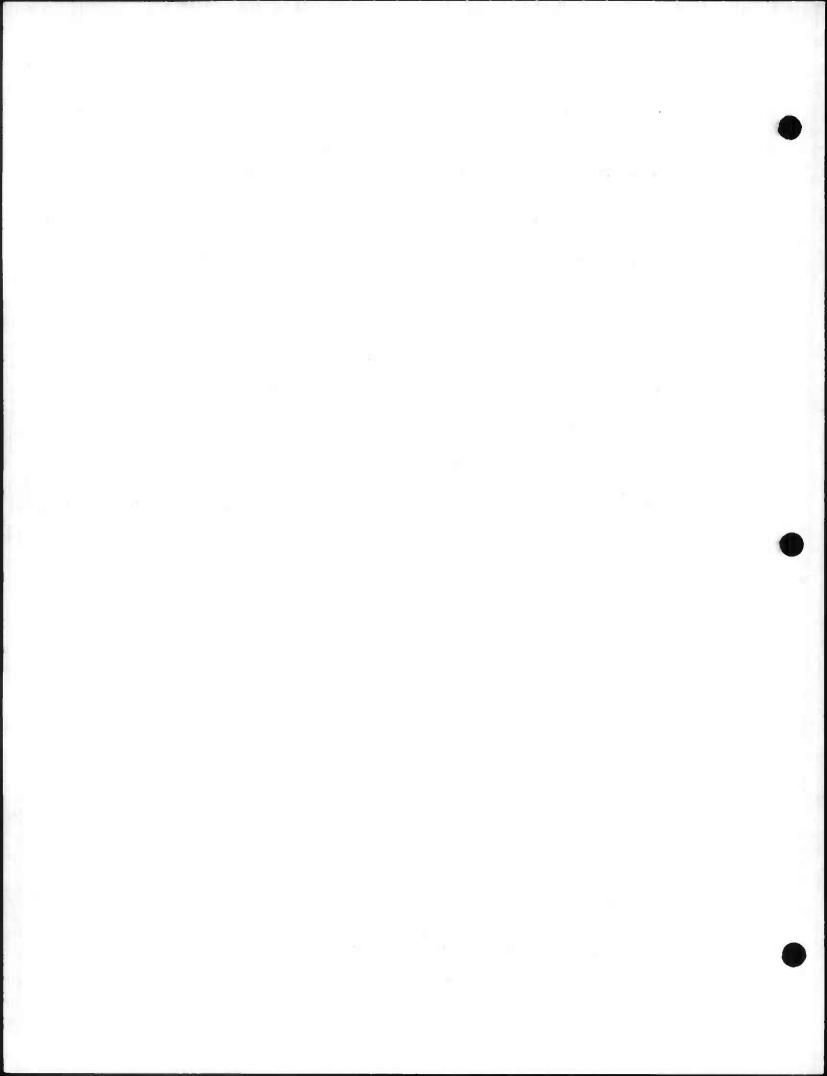




State of Maryland / Department of Health and Mental Hygiene

14822

141						Ce	rtificate o	f Death		Reg. I	No.			
	11.3		1. Decedent's Name (First, Midd	fle, Last)					2. Date of				Time of Death	
	Physic /Medi		Norma C. Johns	son					April		1997 Ye		:55 am	
	Exami		4a. Facility Name (If not institution	on, give street end n	number)			4b. City, Town,	or Location of De		4c. County of D			
			Anne Arundel M	Medical Co	enter			Annapo1	is	A	nne Aru	inde1		
Т	Funeral	Г	5. Social Security Number	6. Sex		lest birthday	If Undar 1 Yas	ar If Under 24	Hrs. 8. Date of	Birth			(Stata or Foreign	
	Director		579-18-5476	1 □ M 2 🖾 F	7.5	Yrs.	Months Day	s Hours N	Nov.	Dey, Yes	921 W	ashin	gton, Do	
	D		Usual Residence of Decedent										80011, 20	
	nylan how		10a. State 10b. Count	У	10c. C	ity, Town or L	ocation				10d. Inside Cit			
	Ma a-fa	tor	MD Anne	Arunde1	Riv	7a					1 ☐ Yes 2 §			
	h they	ie.	10e. Street and Numbar				10f. Zip Code)		10g. (Citizen of What	Country?		
	h wii	Funeral Director	391 Spring Cov	ze Road			21140)		USA				
	deal	ner	11. Marltai Status	12. Was De	cadant Evar in	U,S. 13.	Was Decedent o	Hispanic Origin	(Specify Yes or	-	14. Race - A		ndian,	
0	after or its		1 Navar Married 2 Ma		2 🛭 No				uerto Rican, etc.)			Vhite, etc.		
21215-0020	filed within 72 hours after death with the Maryland rhygiene. ther than "natural;, or Items 23a or 28a-f ahow ont, the Medical Evaryiner must be notined at	by	3 X Widowed 4 ☐ Divorce	d If Yes, G Yaar or			1 □ Yes 2 ☑ N	o Specify:			Specify:	White		
2-0	l within 72 ho liene. r than "natur the Medical	Completed	15. Decede	nt's Education est grede completed	√1	16a. Dece	edent's Usual Occ kind of work don	upation	undina	16b.	Kind of Busine	ess/Industr	у	
21	within and the standard	ple	Elementary/Secondery (0-12)		(1-4or 5+)	life.	DO NOT use reti	red)	working					
21	giene. br then	000	12			Secr	etary			Vi	tro Lah	5		
Maryland	be filed tal Hygi d other event, t	Be	17. Father's Name (First, Middle	, Last)				18. Mother's	Neme (First, Mid	dle, Maid	en Surneme)			
<u>a</u>	should band marked	10	Kirke Kibler					Cathe	rine Gor	man				
al	d 2 should be filed v th and Mental Hygie 7 is marked other t traumatic event, th		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mail	ing Address (Stre	et and Number o	r Rurel Route Nu	mber, Cit	y or Town, Stel	te, Zip Cod	(e)	
	D = Z =		Gail C. Johnso	on		3815	Ingalls	. AVenue	, Alexan	dria	, VA 2	22302		
re	other		20a. Method of Disposition			Place of Disp	osition (Neme of metory or other p		Date	T	Location - City	or Town,	State	
Ĕ	permit. Pages I Department of H Important: if its eny injury or ot once.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other ('s Cemet	•	4/20/0	7 64	lver Sp	arina	MD	
Baltimore,	nit. orta Inju		21. Signature of Funeral Service		1		2. Name and Add	-	4/43/3	1 DI	TAGE 2	TILL	, PID	
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			23a. Part 1. Enter the disease, of	mm o	1000	5	00 Unive	ersity B	lvd., W.	, Si	lver Sp	ring	, MD 209	
			shock, or heart failure. Lis	t only one cause on	each line.	DO HOL GI	iter the mode of d	ying, such as car	diac of respirator	y allost,		fnta	irval Between set and Death	
	Physician /Medical		Immediete Cause (Final	-1	مطما	1 0	1.0.10		И.					
	Examiner		disease or condition resulting in death)	e. (1)	llared	2 Ca	undion	ryopa	Thy			1		
		ē		0 1	Due to	or as a conse	quence of): hear	t di	1					
	uted ansit	Examiner		b. CC	rorca	or as e conse	near	1 010	250 75	a se				
Š	icate be axecuted physician and s the bunal-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		DUB 10 (or ay e conse	quence or).							
68760,	e be rsicia e bur	cal	that initiated events	C	Due to /	01 00 0 00000	nuence of):					-		
200	ertificate be axecuted ding physician and se as the bunal-transit	Medical	resulting In death) Last		Due to (or as a consec	quence or):							
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7. O	that the de led by the s detached	nys	Part II. Other significant conditi										cause of death?	
	as that igned b		perip	heral	vasc	ular	disea	rse	_ '	☐ Yes	2□ No 3□	Probably	4 4 Unknow	
ds	law requiras that the as been signed by th 2 should be detache	d by							24a W	as an au	tonsy 2	4b. Were a	utopsy findings	
Records,	v require been si should l	Completed								erformed		comple	le prior to	
ě	has has	du										of death	17	
<u></u>	The ate	S							1	☐ Yes	2 2No	1 🗆 Ye	s 2□ No	
=	Physician: The this certificata ral director, pag	Be	25. Was case referred to medical examiner?						Death (Check on	ly one)				
of Vital	physic this c	2	1 ☐ Yes 2 No	Hospital: 1 🕽	Inpatient 2	ER/Outpatie	IN SLI DOA		ng Home 5 □ R	esidence	6 ☐Other (5	Specify)		
_		ü	27. Manner of Deeth 1X Natural 5 ☐ Pendi		e of Injury onth, Day Year)	28b. Time of Injury	of 28c. In	jury at lork?	28d. Descri	e how in	jury occurred			
Division	Attending it death. ector: After by the fune	ati	2 ☐ Accident invest	tigation			M 1	Yes 2 No						
Ĕ		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	mined 286. Plac	ca of Injury - At I ding, etc. (Spec	nome, farm, st	reet, factory, offic	а		n (Street Town, St	end Number of	r Rural Roi	ute Number,	
2	rs after rs after all Dir													
	hour uner uner	edlcai	29a. Certifier 1 Certifyl (Check only 2 Medical	ng Physician: To the Examiner: On the	ne best of my kn	owledge, deat	th occurred at the	time, dete and p	lace, and due to t	he ceuse	(s) end manne	r as stated	l.	
	To the Hospital or within 24 hours afta A To the Funeral Dir.		one)	and ma	nner stated.	ation and/or ii		opinion, death c	occurred at the thi	ie, uate a	ino piaca, ano	due to the	Cause(s)	
	With To t	Σ	29b. Signature and title of certific				29c. Lica	nse number		29d. I	Date signed (M	onth, Dey,	Year)	
	8		Mair	e m	aia	12	145	297		C	1-26-	-97		
	9		30. Name and address of person				Print)				41.			
			Elaine 1				000	Kilnolo	e Ave	7	いるの井 1	3/:	MDQLAN	
	Sta	ite	31. Dete filed (Month, Day, Year		Registrar's Sign			.vge re	_ 140		11797	N/W !	201-101	
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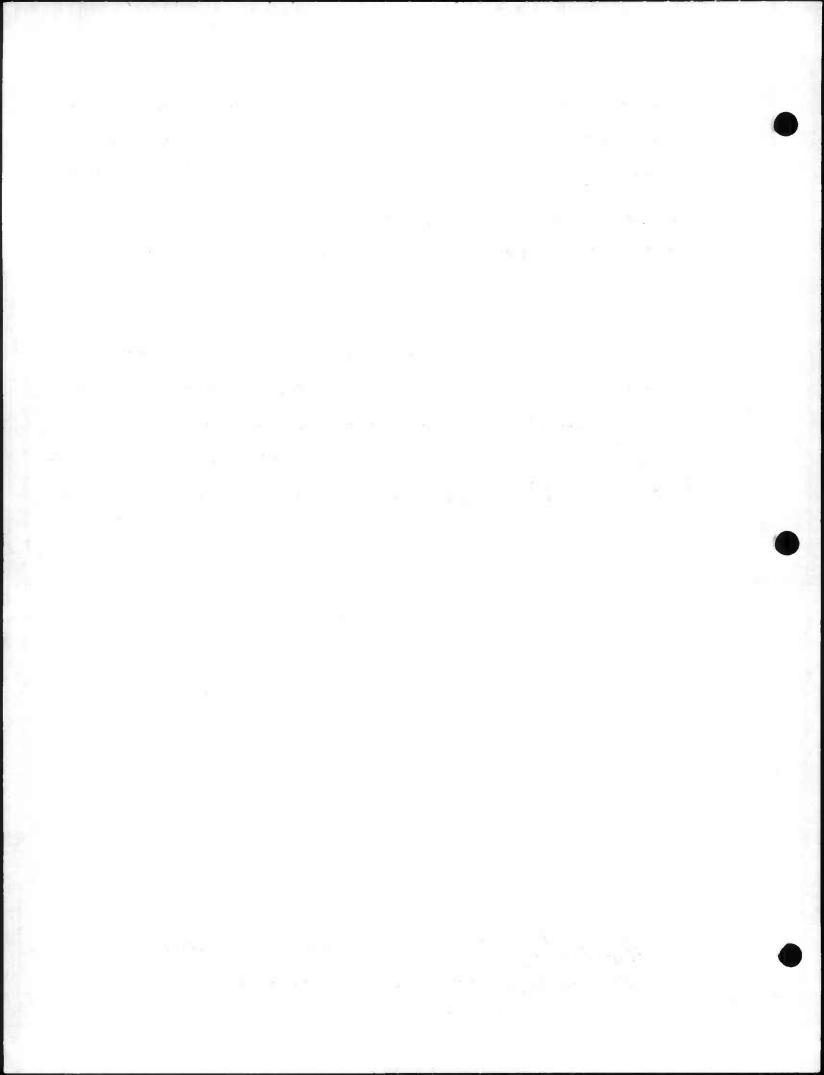
State of Maryland / Department of Health and Mental Hygiene

97 14823

							of Death		Re	g. No.		
	Physic	an	1. Decedent's Nama (First, Middle	, Last)					Data of Death Month		Year	3. Time of Death
	/Medi		CHARLES 1	M. JAMES	JR.			Į į	APR	28	1997	12:15 P
	Exami		4a. Facility Name (If not institution	, give straet end number)		4b. City, T	Town, or Location	on of Death	4c. County	of Death	
			9717 Over	lea Drive				ckvill	le	Moi	ntgome	ery
	Funerai		5. Social Security Number		ge (In yrs. last bi	Months	Year If Unda Days Hours	Min. 8. [Date of Birth Month, Dey,	Year)	9. Birthplac	e (State or Foreign
	Director		409-52-7881	IM SOF	57	Yrs.		Se	ept 18	3,193	9 Ter	nn.
	pu *		Usual Residence of Decedent 10a. Stata 10b. County		10c. City, Tow	m or Location					line	to side Oh at inch
	sho sho	5	Too. County								10d. Inside City Limits 15 Yes 2 □ No	
	Ne N	Director		gomery	RC	ckville						
	death with the Maryland rms 23a or 28a-f show		10e. Street and Number	on Duding		10f. Zip (10		What Country	?
	ath v	- a	9717 Overl				850			U.S.A		
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forcas	?	13. Was Decede If Yes, specif	int of Hispanic O ry Cuban, Mexica	origin? (Specify an, Puarto Rica	Yes or No- n, etc.)		ce - American ck, White, etc.	
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3	hour			Year or Dates:	1.40	D = 1 = 1 = 1					Blac	
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7	il Hygiene. other than "	E	Elementary/Secondary (0-12)	College (1-4or	5+) S	ystem E		r		T.F	В.М.	
			17. Father's Name (First, Middle, I	8 Yrs		4		her's Name (Fir	et Middle M			
Maryland	0 0 0 0	Be	-	James Sr.							110)	
5	should be and Mental marked o	10			400			Duane	King		0.11	
2	12 sho h end 7 is me traum		19a. Informant's Name/Relationsh			o. Mailing Address (,
	as 1 and 2 should of Health and Mer- ltam 27 is marke other traumatic		Mrs Emma J. (20a. Method of Disposition	James (Wif		717 Ove						
altimore,	Pages nent of h int: if ha		1 Burial 2 Cremation	3XRemoval from State	cemete	ry, cremetory or oth	er plece)				City or Town	
	tant tant		4 Donation 5 Other (Sp	- 1	Jarni	gan &So			/30 F	(noxvi	ille,	Tenn.
0	permit. Pages Department of Important: If I any Injury or otice.		21 Signature of Funeral Service I	0//	A	Charada	Addrass of Faci	man I II o	D	7 20	0000	
	005 0		20a Part Enter the disease, or shook, or heart failure. List	K. / Jun	ndu	Snowde	n rune. Washi	rat no	g+ F	A. ZU	115	Md
			20a Part Enter the disease, or shock, or heart failure. List	complications that cause	d the death. Do	not enter the mode	of dying, such a	s cardiac or res	piratory arra	st,	Ar	oproximata tervel Between
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	/Medical		Immediete Ceuse (Finat disaese or condition	I	LUNG CA	NCER						2Yrs
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· ·	e executed ian and urial-transit	I Examiner	if any, teading to immediate cause. Enter Underlying	b	- 1011							2115
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necolds, r.o. po	To the Hospital or Attanding Physician: The law requires thet the death within 24 hours after death. To the Euneral Director: After this certificate hes been signed by the etter completely filled in by the funeral director, page 2 should be deteched for a	Certification: To Be Completed by Physician/Medical	ary, teading to immediate cause. Enter Underlying Cause (Disease or injury that Initieted events resulting in deeth) Last Part II. Other significant condition 25. Wes case referred to medical examiner? 1	Hospital: 1 Inpati 28a. Dete of Injuination of be lead 28e. Placa of Induiting, eleading, eleading physician: To the best examiner: On the basis of	Due to (or as a put not resulting in the put not resulting in the put not resulting in the put not resulting in the put not resulting in the put not resulting in the put not resulting in the put not resulting in the put not not resulting in the put not not not not not not not not not no	consequence of): consequence of): n the underlying cau utpatient 3 DOA Time of Injury M arm, street, factory, e, deeth occurred at Ind/or investigation, in	26. Place Other: 4 No. Injury at Work? 1 Yes 2 offica the time, dete en my opinion, de	ce of Death (Ch.	1 Yes 24a. Was an perform 1 Yes 24c only one 5 Alesider Describe how Location (Strate City or Town, due to the cert the time, date	autopsy ed? SMNo Outce 6 Other Injury occurring the state of the sta	3 Probeb 24b. Were availa comploof dea 1 Y Y Her (Specify) red Der or Rurel Reand due to the and due to the discount.	e cause of death? All Unknown autopsy findings ble prior to lead th? as 2 \sum No oute Number, ad. e ceuse(s)
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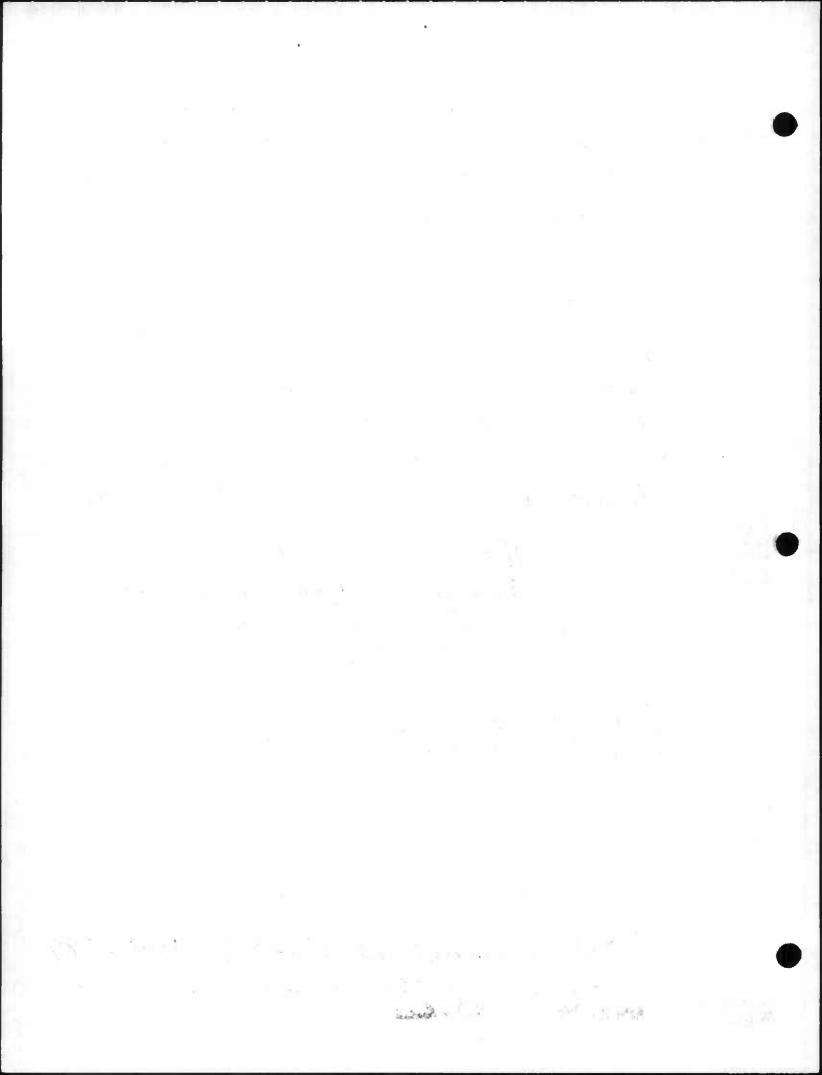
				State	of Maryla		artment of I rtificate of			1ental Hy	/giene Reg. No.	97	14824	
	Physic /Medi		Decedent's Name (First, Mid Eleanor Jae							2. Dete of Do Month April	25,1997	Year	3. Time of Death 12:00 P.M	
7	Exami		4e. Facility Name (If not Instituti Stella Maris		num <i>ber)</i>			4b. City, To		ocation of Deet		y of Death timor	'e	
Ī	Funeral Director		5. Social Security Number 577–03–2045	6. Sex 1 □ M 2 F	7. Age (In y	rs. lest birthday) 85 Yrs.	If Under 1 Year Months Deys	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth	9. Birthp	place (State or Foreign Torado	
	Maryland f show	lor	Usuei Residence of Decadent 10a. State 10b. Count Maryland Balt:			City, Town or Lo					10d. Inside City Lir 1 ☐ Yes 2 🖔			
	h with the 3a or 28a at be notifi	Funeral Director	10e. Street end Number 713 Maiden Cho				10f. Zip Code 21228	3			10g. Citizen of What Country? U.S.A.			
020	72 hours efter deeth with the Maryland "natural", or flems 23a or 28a-f show added Examiner must be nutitled at	þ	11. Maritai Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed	s 2XXNo		Was Decedent of In Yes, specify Cub		gin? (Sp.	ecify Yes or No Rican, etc.)	14. Ra Bis	ce - Americ ick, White, fy: wh		
Maryland 21215-0020	d within giene. r than "	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education est grade complete College	d) (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	t of work	ing	16b. Kind of E	dustry		
ryland	should be filed and Mental Hygies marked other turnetic event,	To Be C	17. Father's Neme (First, Middle Lester Sto	one				Eli	.zabe	eth Pal				
Baltimore, Ma	of Health er item 27 Is other trau		19a. Informant's Name/Relation Rev. George Jo 20a. Method of Disposition 1 Burial 20 Cremation 4 Donation 5 Other (aeger/Son	m State	4136 Place of Dispo cemetery, cree	Buckner Buckner Sition (Name of matory or other pla itian Cre	La. F	aduc	cah, Ke	ntucky 20c. Location	42001 - City or To	own, State	
Balt	Department of Important: If any injury or once.	N	#1 Signature of Funeral Service		Jan 1	22	2. Neme and Address	ss of Facilit	y Tak	koma Fu	neral H	ome, I	nc.	
	Physician /Medical Examiner	er	23a. Part. Enter the dilease, canock, or heart favore. List immediate Cause (Finel disease or condition resulting in death)	t only one cause or	ENDSTAG		DYSPLASIA		cardiac (or respiratory a	rrest,		Approximate Interval Between Onset and Death 6 weeks	
68760,	cete be executed physician end the burlet-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	b		(or es a consec						1	- 42	
Box 6	deeth certific e ettending p ed for use es	(a)		d								1		
P.O.	that the ed by th detache	y Physician/M	Part II. Other significant conditi	ons contributing to	death but not re	esulting In the u	nderlying cause gl	ven in Part I.					the cause of death? bably \$\int\Unknown	
Vital Records,	aw requires seen s	Completed by									an autopsy ormed?	eve	ere autopsy findings eilable prior to mpletion of cause death?	
ital F	The page	Be Cor	25. Was case referred to medical examiner?	ai				26. Piece	of Death	1 Check only	Yes XXNo	1[Yes 2 No	
o	iling Phys h. After this funeral di	2	1 Yes No 27. Manner of Death Natural 5 Pendi	28e. Dat	Inpatient 2 e of Injury enth, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injur Wor	4 □ Nu	1		dence KXOti how injury occu) Hospice	
Division	Hospital or Attend 24 hours efter death Funeral Director: stely filled in by the	Certification:	3 Sulcide 6 Could 4 Homlcide deter	nined 256, Pl6	ce of Injury - At ding, etc. (Spec	home, farm, str	eet, factory, offica			28f. Location (City or To	Street and Num wn, State)	ber or Rura	il Route Number,	
	To the Hospital or within 24 hours effer To the Funeral Dir completely filled In	Medical	one) 2 Medical		e best of my kr basis of examin nner stated.	nowledge, death netion and/or inv	estigetion, In my o	pinlon, deet	d place, e h occurr	end due to the ed at the time,	dete end placa,	and due to	the cause(s)	
	4		29b. Signature and tiffe of certific	ute	4L		29c. Licens D155				April 2			
	5		30. Neme and eddress of person Dr. Eddie No	khuda 23			Print) lley Rd.	Tows	on,	MD 212	04			
		State Registrar 31. Date filed (Month, Day, Year) APR 2 8 1997 32. Pegistrer's Signature APR 2 8 1997												



State of Maryland / Department of Health and Mental Hygiene 97

14825

			Certificate of	of Death	Reg	g. No.		
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Mildred Ann Jorgensen		2. Date of Death Month April 27	Day Year	3. Time of Deeth 6:26 P.M.	
7	Exami	ner	4a. Fecility Name (If not institution, give street and number) 314 Brockton Road	4b. City, Town, or Oxon Hil		4c. County of Deet Prince Ge		
10	Funeral Director		5. Social Security Number 341-18-7822 6. Sex 7. Age (In yrs. last birthday) Months De				hplace (State or Foreig untry) inois	
	death with the Maryland ms 23a or 28a-f show irnust be nutified at	tor	10a. State 10b. County 10c. City, Town or Location Maryland Prince George's 0xon Hill				10d. Inside City Limit	
	r 28a	Director	10e. Street and Number 10f. Zip Cod	le	100	g. Citizen of What Co	untry?	
	3a or	D	314 Brockton Road 2074	5		U.S.A.		
		Funeral		of Hispanic Origin? (S Suban, Mexican, Puerl	specify Yes or No-	14. Raca - Ame		
0050		by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Sive Yeer or Dates: If Yes 2 ☑ II ☐ Yes 2 ☑ II		o Hican, etc.)	Specify: White	k, White, etc. White	
21215-0020	within 72 h ena. than *natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	cupation ne during most of wor tired)	rking	6b. Kind of Business/	Industry	
	filed wil Hygien: ther tha	Con	10 Homemaker			Own Home		
pu	0 = 0 5	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, Ma	uiden Sumame)		
Va	should be ad Mente marked matic ev	To	Theodore A. Schulz	Johann	na Dostal			
, Maryland	od 2 s Ifh ar 27 is r trau		19a. Informant's Name/Relationship (Type, Print) Robert C. Jorgensen/Husband 19b. Mailing Address (Str. 314 Brockton				Zip Code)	
ore	of Healt Itam 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other)	nlace)	Date 20	Oc. Location - City or	Town, State	
E	Page nent o nnt: If		XXBurial 2 Cremation 3 Removal from State 4 Dogation 5 Other (Specify) St. Barnabas Epi		Cem.5/1/97	Temple H	ills. Md.	
Baltimore,	permit. Pa Departmen Important: any Injury 2009.		21. Signature of Funeral Service Licenses 22. Name and Ad George	dress of Facility P. Kalas	Funeral H	ome		
~	-		23a. Part1. Enter the please, or complications that caused the death. Do not enter the mode of	xon Hill R			20745 Approximate	
30x 68760,	th certificate be executed xx beneficially by sicial and rusa es the burial-transit and	an/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Arthrosellustic Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Corelar Carder	vocal	on DIK		
P.O. B	requiras that the deeth een signed by the atte hould be deteched for	Physicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.			to the cause of death	
	as the iigned be de	by P	Dull almente			20110 0011	outly 4 division	
Records,	> 10 0	Completed	Hyperthyporderin		24a. Was an performe	ed? 8	Were autopsy findings available prior to completion of cause of death?	
æ	0 - 0	E O	v		1 ☐ Yes	2 🖔 No 1	Yes 2 No	
ta	lcian: The	Bec	25. Was case referred to medical	28. Place of Dea	ath (Check only one)		2.00	
of Vital	Physician: r this certific tral director,	To	examiner? 1 Yes 2 No	_		ce 6 Other (Spec	cify)	
ion o	To the Hospital or Attending Ph within 24 hours efter deeth. To the Funeral Director: After thi complately filled in by the funeral			njury at Vork? Yes 2 No	28d. Describe how			
Division	af or Attendis s efter deeth. I Director: A d in by the fu	Certification:	3 ☐ Sulcide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	ce	28f. Location (Stre- City or Town,	et and Number or Ru State)	ral Route Number,	
	To the Hospital or Attending F within 24 hours elfar deeth. To the Funeral Director: After complately filled in by the funer	edicai (29a. Certiflier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the analysis of exemination and/or investigation, in m and manner stated.	time, date and plece y opinion, deeth occu	, end due to the cau- rred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)	
	To th Within	W	29b. Signature and title of certifier 29c. Lice	anse number	290	Dete signed (Month	8, 97	
	8)		30. Name end address of person who completed cause of death (Itera 3a) (Type, Print) R. A. McConnaughy, M.D. 11418 Livingston	Dd Er	Wachi ·	On Md 2/	7//	
	Sta Registr	_	R. A. McConnaughy, M.D. 11418 Livingston 31. Dete filed (Month, Day, Year) APR 29 1897	I NU., FT.	wasiiingt	on, rid. 20)/44	



State of Maryland / Department of Health and Mental Hygiene

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ITEM: 5 per INFOR G-747 5-30-97 eoh Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Day Thomas Hardy Jones April 23, 1997 10:50 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Collington Health Care Center Mitchellville Prince Georges | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 8. Date of Birth | Month, Day, Year) | 1912 | 9. Birthplace (State or Foreign Country) 5. Sociel Security Number 15 6. Sex 1 → M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 080 - 09 - 521385 Yrs Director February 17, Virginia Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show naunt be notified at 1 Yes 2 No by Funeral Director Virginia Brunswick Lawrenceville 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 6 20072 Christanna Highway 23868 permit. Pages 1 and 2 should be filed within 72 hours after death vibepartment of Health and Mental Hygiene. Important: If then 27 is merked other than "natural", or items 23-sary injury or other traumatic event, the man United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Raca - American Indian, Bleck, White, etc. 1 ☐ Yes 2/0XNo If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) College Professor years plus St. Paul's College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Jones Clarence Washington Anna Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10215 Buena Vista Avenue, Seabrook, Maryland 20706 Hardi L. Jones (son) 20b. Placa of Disposition (Name of cemetery, crematory or other placa) April 28, 1997 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Chapel Cemetery Lawrenceville, Virginia 22. Name and Address of Facility Latney's Funeral Home, Inc-21. Signature of Funeral Service Licensee Humos Latney 3831 Georgia Avenue, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Division of Vital Records, P.O. Box 68760, the attending physician thed for use as the buria Qu C Physician/Medical Due to (or as a consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evallable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 1 Yes 212 No certificate 1 ☐ Yes 2 ☐ Ner Hospital or Attending Physician: Be 25. Was case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural death. 1 Yes 2 No after death 2 Accident illed in by the 3 Sulcide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) end manner stated. Medical 29a. Certifier (Check only one) 5 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) 1997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman Ř. Tuli, M.D.; 10810 Darnestown Road;Suite 202;Gaithersburg,Maryland 20878 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

STANDERS PORCH

DHMH 16 Rev 6/95

Registrar

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State of Maryland / Department of Health and Mental Hygiene 97 | 4827

					(Serti	ficate o	of D	eath			Reg. No.		
Physic /Med		1. Decedent's Nama (First, Middla, Last) Wallace Jones								2. Data of Do Month May	3. Time of Directh			
Exami		4e. Facility Nama (If not institution, Calvert County	and the second second		er						ocation of Dee ederick		y of Death lvert	TES
Funeral Director	_	5. Social Security Number 220-28-5171 Usual Rasidence of Decedant	6. Sex M M 2□ F	7. Age (in)	yrs. last birth	day) A	If Under 1 Ye Months Day		If Under Hours	24 Hrs. Min.	8. Dete of Bi (Month, D Jan. 5	rth ay, Year) 5, 1932		elece (State or Foreign try) ryland
Maryland -f ahow	lor	10a. Stata 10b. County Maryland Calv	vert	10c.	City, Town		tion ingtown	n					1	0d. Inside City Limit
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Director	10e. Street and Number					10f. Zip Code	8			T	10g. Citizan of	What Cour	itry?
3a o		4465 Harvey Ro	nad				206					USA		,
be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be inclined at	by Funeral	11. Maritel Status 1 Never Married 2 Merrie 3 Widowed 4 ŽiDivorced	12. Was Dec Armed F	2X No	n U,S.	lf Y		f Hispuban,	penic Ori , Maxicar Specify:	gin? (Sp n, Puerto	ecify Yes or N Rican, atc.)			
2 hou	P	15. Decedant's		Datas.	16a. E	ecedar	nt's Usuai Occ	cunati	ion			16b. Kind of Business/Industry		
al Hygiene. I other than "n	Completed	(Specify only highast Elementary/Secondary (0-12) 7	grada completed)) (1-4or 5+)	(Giva kin ifa. DO	of work doi NOT use ret aborer	na du	iring mos	t of work	ing		truct	
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as 1 as 1 of Hee		20a. Method of Disposition 1	3 □Removei from		b. Piece of E cematary,	Dispositi crama i	ion (Name of tory or other p	olece))	i	Date	20c. Location	- City or To	wn, State
permit. Pagas 1 au Department of Hea Important: If Item; any Injury or other once.		4 ☐ Donation 5 ☐ Other (Spe		7	Young'	s Cl	nurch	Cen	n.	į.	5/10/97	Hunti	ngtow	n, MD
Depart Depart Import any In		21. Signature of Funerel Sarvice LI	Icensaa			22. N	lama end Add	dress	of Fecilit	y Ser	well Fu	meral H	ome	
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that the death certificate be assectled with the death certificate be assectled with attending physician and datached for use as the burial-transit	edical Examiner	Immediate Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Disease or injury that initiated avants rasulting in death) Last	a	Due to	o (or as a co	nseque	nce of):	Of	dia	904	1 Ca	VC I DOI	27.69	
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aw requires been s	Completed											s an autopsy ormed?	av	ere autopsy findings allable prior to mpletion of causa daeth?
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ysician: This cartificata director, pag	Be	25. Was casa rafarred to medical exeminer?						:	26. Place	of Deat	h (Check only	ona)		
0 0	9	1 ☐ Yas 2 No	Hospital: 1 🗆	Inpatiant 2	≥ □ ER/Outp	atient	3LI DOA	Other	SEO NU	irsing Ho	me 5□Res	Idance 6 🗆 Oti	har (Specif	v)
right.	Certification:	27. Mennar of Death Netural 5 Panding 2 Accident invastiga 3 Suicide 6 Could no	ition	of Injury oth, Day Year	28b. Tir		28c. In V		at as 2		28d. Describe	how injury occu	rred	
ital or Attendi irs aftar death. ral Director: A lied in by tha f		4 ☐ Homicida determin	had 288. Place build	ling, atc. (Spe	ecify)		, factory, offic				City or To	(Street and Num wn, Stete)		
To the Hospital or within 24 hours aftar To the Funeral Dire complately filled in b	fedical	one) 2 Medical E	Physician: To the xaminer: On the b and man	a best of my i pasis of axam nnar stated.	knowledge, or ination end/	daath od or invas	tigation, in m	y opir	nion, daa	d piace, th occur	and dua to the red at tha time,	, date and pieca,	and dua to	tha causa(s)
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2		30. Nema and addrass of person will Jonathan Lowe	enthal, M	1. D.		ype, Pri	nt)		Pri	ince	Freder	cick, MD		
Sta Regist		31. Data filed (Month, Day, Year)	07 1997	Registrar's Si	Saucles	w Ra	rdall							

TEIGHT ...

State of Maryland / Department of Health and Mental Hygiene

14828 Certificate of Death

п			Decedent's Neme (First, Middle,	Last)							2. Dete of De		Maria	3. Time of Death
	Physic /Mod		Florence	Ρ.	Kern						Month	29, 199	Year 7	12:10PM
	/Medi Exami		4e. Fecility Neme (If not institution,	give street end nu					4b. City, Tov	m, or L	ocation of Dee			
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Т	, Funeral			. Sex	7. Age (In yrs.	last birthday)	If Under		r If Under 2	4 Hrs.	8. Dete of Bi	rth		•
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	_		Usuel Residence of Decedent),)						April	0,1902	Net	w York
	lan M		10a. Stete 10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside City Limits
	the Man 28a-f sh	Director	Maryland Mont	gomery			100 70		Bethe	sda			1 □ Yes 25	
	ath with 23a or		7808 Marykno				10f. Zip		2081			United	of Whet Country?	
21215-0020	n 72 hours efter death with the Maryland "natural", or items 23s or 28s-f show adjust Examiner must be notified at	by Funeral	11. Maritel Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed F	2 ☑ No ive	1	If Yes, specify Cuban, Mex		ban, Mexican,	enic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.) Specify:				
5-0	within 72 ho iene. r than "natur r ve Medical	tec	15. Decedent's (Specify only highest)	Education		16e. Deced	16e. Decedent's Usuel Occupetion (Give kind of work done during)			ion			usiness/ind	
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Baltimore,	permit. Pages Department of Important: If it any Injury or once.		4 ☐ Donetion 5 ☐ Other (Spe			Gre	enwo	bc.	Cemeter	у		Brook1	yn, N	New York
Sal	Departiment Important In once.		21. Signature of Funeral Service Lic	ensee	10	R_0^{22}	Name en	Addr	ess of Fecility Pumph I	ev	Funera e Inc 20814-	L Home		
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	11/1/2		23a. Pert1. Enter the disease, or co shock, or heart falture. List on	mplicetions thet	caused the deal	h. Do not ent	er the mod	ie of dy	ing, such es c	ardiec	or respiretory	errest,		Approximete
	Physician		Shock, of fleat failure. List on	y one ceuse on	eech line.								t	fntervel Between Onset end Deeth
9	/Medicai	П	Immediete Cause (Finel										i	
	Examiner		disease or condition resulting in deeth)	еРт	neumonia									
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	ficate be axecuted physician and st the buriel-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate	Due to (or es e consequenca of):										
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87	death certificate be e attending physicia ed for use es the bur	cian/Medical	thet initieted events resulting in deeth) Last	Due to (or es e consequence of):										
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8	then or us	an	_	·										
			Pert II. Other significant conditions	contributing to d	eeth but not res	uiting In the ur	nderlylng c	ause g	iven in Pert I.		23b. Dfd	tobacco use co	ntribute to	the cause of death?
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Division of Vital Records,	v requi	Completed by									24e. Wes	en eutopsy ormed?	COI	ere autopsy findings eilable prior to mpletion of cause death?
æ	The lav	Ē									10	Yes 2000		
a	n: Ti ficati or, pe		OF Mos and referred to medical										11	Yes XX No
5	Physician: The Land the This certificate he rail director, page	Be	25. Wes case referred to medical exeminer?	Hospital:				O			h (Check only			
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E C	h. After fune	5	1 Neturel 5 □ Pending		of Injury th, Day Year)	28b. Time of fnjury		8c. Inju			Zdu. Deschoe	how injury occur	190	
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<u> </u>	after deat Director:	Certification:	4 Homicide determine	d 280. Piece	of Injury - At he ng, etc. (Specif		et, fectory	, office			28f. Location (City or To	Street end Numi wn, Stete)	oer or Rura	I Route Number,
	ital rai D													
	the Hospital or Attending Ph nin 24 hours after death. the Funeral Director: After th npletely filled in by the funeral	edical	29a. Certifier	hysician: To the	best of my kno	wiedge, deeth	occurred	et fhe ti	ime, dete end	plece,	end due to the	cause(s) end m	enner es st	eted.
	the Ho thin 24 the Fu mpletel	B	Une)	end man	ner steted.	Short into	- Serigotion,	, y	-pinion, dodli	- ooutil	ou or me ume,	aata anu piace,	O) 800 010	ino causo(s)
	15 t E	2	29h Sloneture and title of contifier				20-	Linan	ee number			20d Deta alexa	d /Adomete	Day Vaarl

To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by

Helene Freeman, M.D. State MAY 02 1997 Registrar

29b. Signeture end fitle of certifier

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

4910 Massachusetts Avenue, N.W. #312 Washington, D.C. 20016

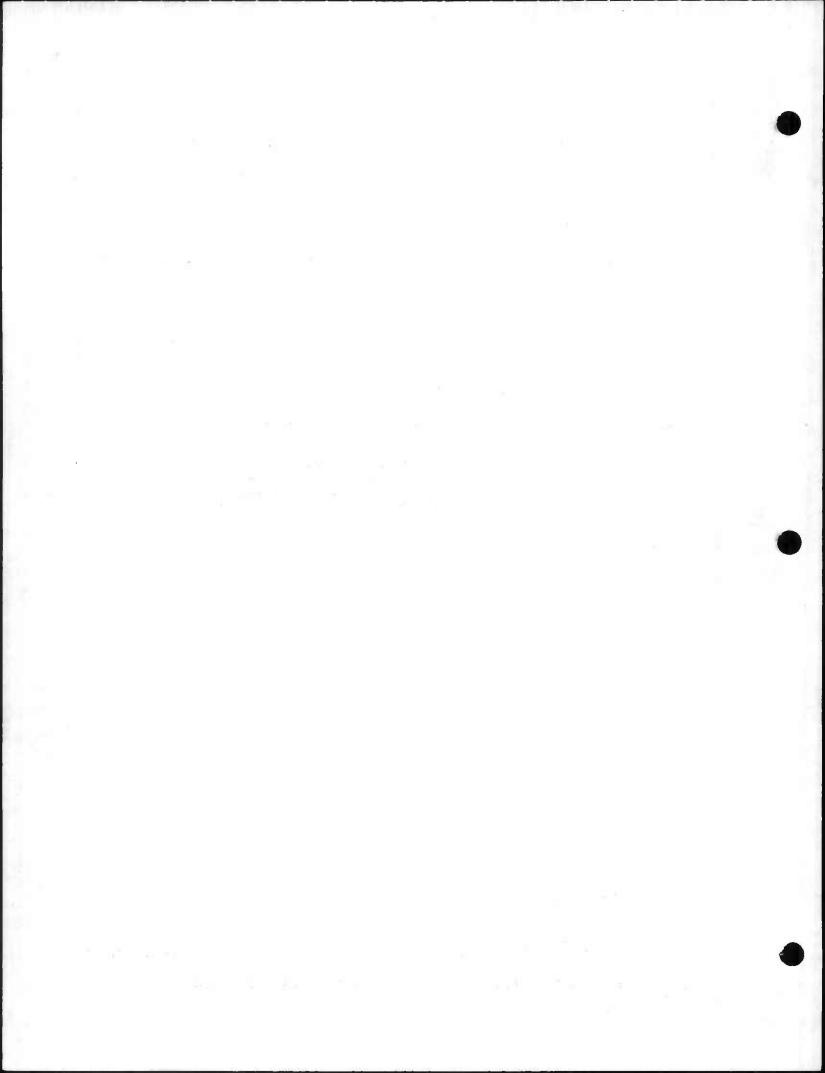
29c. License number

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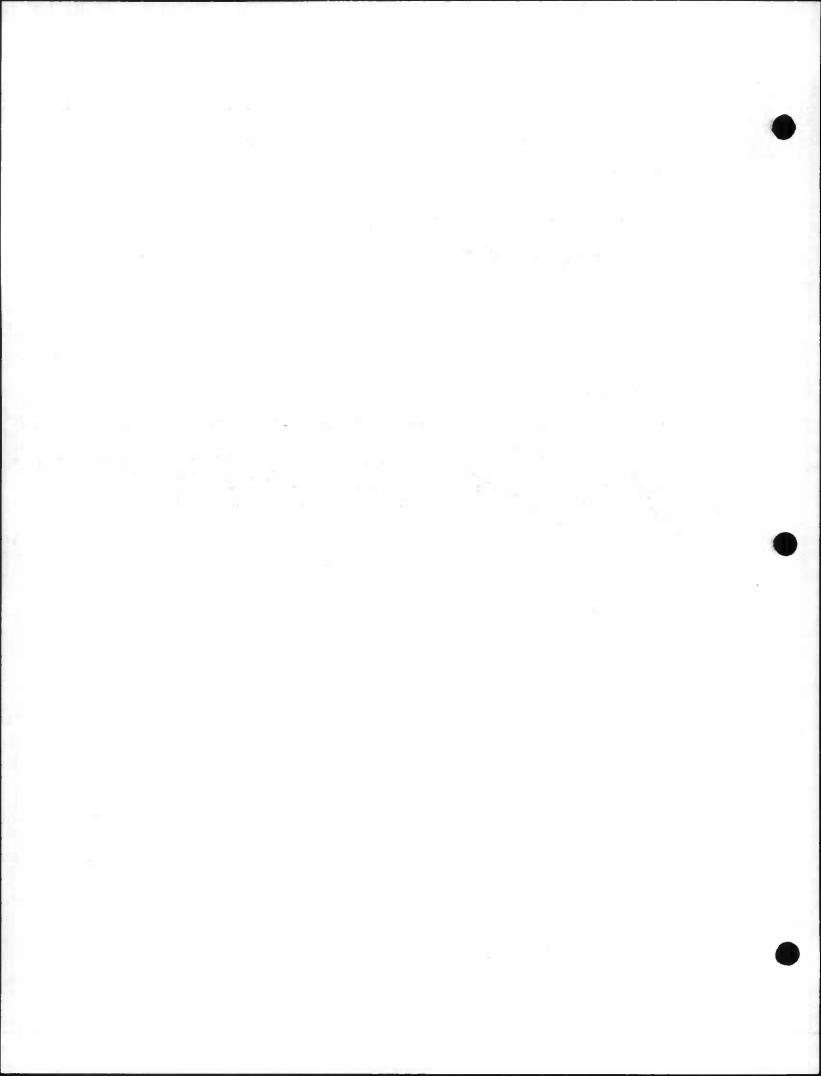
29d. Dete signed (Month, Dey, Year)

April 30, 1997

DHMH 16 Rev 6/95

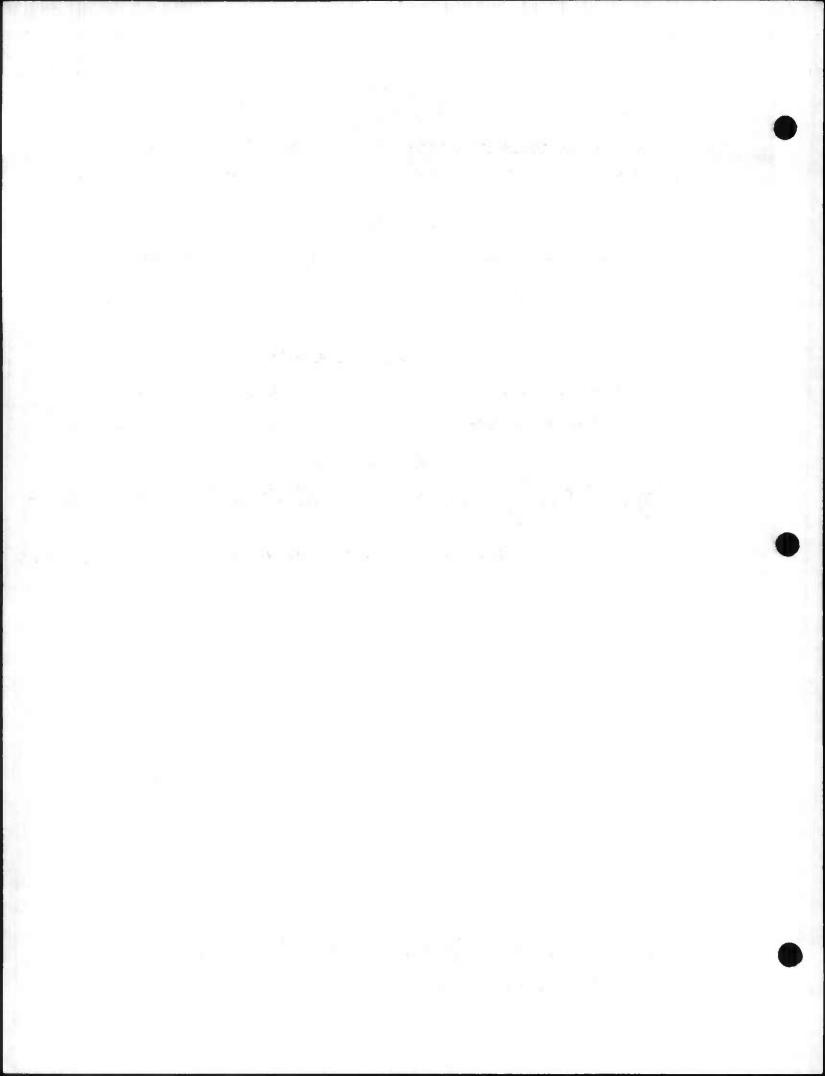


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Social Social Social Social Number 233-70-5496 233-70-	ace (State or Foreigny) Od. Inside City Limit 1 Yes 2 N Intry? an Indian, orean ustry
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Silver Spring, Maryland 20904	
Silver Spring, Maryland 20904	
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	ebly 4 ☐ Unkno
com of d	re autopsy findings illable prior to apletion of cause leath?
24a. Was an autopsy performed? 24b. Wer avail com of di	Yes 2□ No
25. Was case referred to medical 26. Place of Death (Check only one)	
P 1 Yes 20 No Hospital: 1 Inpetient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify,)
27. Manner of Death 1 Natural 5 Pending Investigation 28a. Date of Injury 28b. Time of Injury Month, Day Year) 28b. Time of Injury M 1 Yes 2 No	
28a. Date of Injury at Work? Natural Suicide A Homicide Suicide A Homicide Suicide A Homicide Suicide	
29a Cartifier (Microfifting Physician) To the heat of my beguined as death accurred at the time date and increased as the supplying the state of the supplying the supplyi	Route Number,
(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end manner as set (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end manner as set (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end manner as set (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner as set (Check only one)	eted.
A DIZZOZ	eted. the cause(s)
30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)	eted. the cause(s)
30. Name end address of person who complete cause of deeth (Item 23a) (Type, Print) DAVID 5. ETT NGC 17.0, The Johns Hopkins Oncology (enter Balto MD) State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	eted. the cause(s) Day, Year)



			5	State of Marylan		rtment of tificate of		Mental Hy	rgiene 9	7 1	4830
			1. Decedent's Neme (First, Middle, Last)	-				2. Dete of De	-		3. Time of Deeth
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	/Medi Examir		4e. Facility Neme (If not Institution, give stre	et end number)	\wedge	USPIG	4b. City, Town, o	r Location of Deal	th 4c. County		2000 b.11
	Exami	iei	and the second s				Rockvi				
Н	Funeral		SHADY GROVE ADV 5. Social Security Number 6. Sex	/ENTIST HOSP 7. Age (In yrs.		If Under 1 Yea	r If Under 24 Hi	s. 8. Date of Bi	rth	omery 9. Birthola	ce (Stete or Foreign
г	Director		104-36-5251 ¹□M	201 F 50	Yrs.	Months Deys	Hours Mi	n. (Month, Di	ey, Year) 4, 1946	New	ce (Stete or Foreign y) Vork
ч			Usuel Residence of Decedent					July	4, 1940	NEW	IUIK
	ylan		10e. Stete 10b. County	10c. Cit	y, Town or Loc	ation				100	d. Inside City Limits
	Mar	to	Maryland Montgomery	· G	aithers	burg					1 ☐ Yes 2 No
	r 28	Director	10e. Sfreef and Number			10f. Zip Code		1	10g. Citizen of V	Whet Country	y?
	N WIE		14050 Great Notch	Terrace		208	78		United	State	Q
	De filed within 72 hours after death with the Maryland nial Hygiene. Id other than "natural", or flams 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marifel Stetus 12.	Was Decedent Ever in U	S. 13. W		Hispanic Origin? (ben, Mexicen, Pue	Specify Yes or No		a - American	n Indian,
0	or he		1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No 197	74-			orto Rican, etc.)	Blec	k, White, et	c.
05	el', c	Ď	3 Widowed 4 Divorcad	If Yes, Give Yeer or Detes: 190		☐ Yes 2 X No	Specify:		Specify	: Whit	te
21215-0020	72 ho	Completed	15. Decedent's Educat	on	16e. Decede	ent's Usuet Occu	petion		16b. Kind of Bu	siness/indu	stry
21	C 2 63	ple	(Specify only highest grede of Elementery/Secondery (0-12)	College (1-4or 5+)	life. D	O NOT use retir	e during most of w ed)	orking			
21	d with giana.	0		5+	Licensed	Nurse	Practiti	oner	Pedia	trics	
b	al Hygie other	Be (17. Fether's Neme (First, Middle, Last)						, Meiden Sumem	e)	
/la	should be filed within and Mantal Hygiana. marked other than umatic event, the Mantal Control of the Mantal C	10	Edward John Kaspr	zak			Elizab	eth Ther	esa Mala	chows	ki
Maryland	2 sho and h is ma		19e. Informent's Neme/Retetionship (Type,	Print)	19b. Mailing	Address (Stree	et end Number or I	Rural Route Numb	er, City or Town,	Stete, Zip C	Code) 20878
	ロキトラ		Kenneth Edward Kas	przak/Brother	14050	Great 1	Notch Ter	race. Ga			
ore	itan itan oth		20e. Method of Disposition	20b. P	leca of Dispos	ition (Neme of	eca)April 28	Date	20c. Location -		
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á	afta Dire	er	4 Homicide	building, etc. (Specify		, ,,		City or To	wn, Stete)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this carificocomplataly filled in by the funeral director.		29a. Certifier 113 Certifying Physicis	n: To the best of my know	wledge death	occurred at the t	ime date end pled	a and due to the	cause(s) and me	nner es stet	led
	24 h Fur ataly	edical	(Check only 2 Medical Examiner:	On the basis of exeminat	tion end/or tnve	estigetion, in my	opinion, death occ	curred et the time,	dete end pleca, e	end due to the	he cause(s)
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	10+1		They will M.	Juggery 1		11.0		(MYRIL	24	144.(
			30. Name and address of person who comp	eted cause of deeth (Item	23e) (Type, P	rint)	Calma) \0,"	o Pari	14110	1997 20850 MJ
			31. Dete filed (Month, Dey, Year)	32. Registrer's Signe		UNAL	CENTER	- DE IU	e ruck	VILLE	1100
	Sta Registr		APR 2 8 1997	Julia Davidson	%						
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Jula Davidson Bondall



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Carroll County, wjl State of Maryland / Department of Health and Mental Hygiene 483 Amended Item #3, Per Physician, Certificate of Death 4:05 PM 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month APRIL 3 O **Physician** 1997 JAMES LEE KELBAUGH 4-30PM /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 1 X M 2 □ F 217-38-4910 56 **Director** Feb. 9, 1941 Maryland Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 28 or 28a-f show any injury or other traumetic event, the Medical Examiner must be nonlined. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Carroll Westminster 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 906 Cindy Lane 21157 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☒ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Warehouse Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) James E. Kelbaugh Shirley Webb 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sherri Kelbaugh - Wife 906 Cindy Lane, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation 5/2/97 Hampstead, MD 21. Signeture of Funerel Bervice Licensis 22. Neme end Address of Fecility Fletcher Funeral Home 254 E. Main St., Westminster, MD 21157 for the discusse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical months **Examiner** Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burlef-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): attending pl signed by the a d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 3 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evelleble prior to completion of cause of death? 24e. Wes en autopsy performed? Completed page 2 s 2 110 certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical exeminer? 89 26. Plece of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred **↑** DNeturel 5 Pending death. 1 TYes 2 TNo 2 Accident investigation ofter death Director: 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours of To the Funerei D completely filled 29e, Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as atted. edical 2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. (Check only one) 29b. Signetyre end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar HAROLA

7801 YORIC RA#203 BALTO, MA 21204 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture MAY 02 1997

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

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M.D

State of Maryland / Department of Health and Mental Hygiene 97

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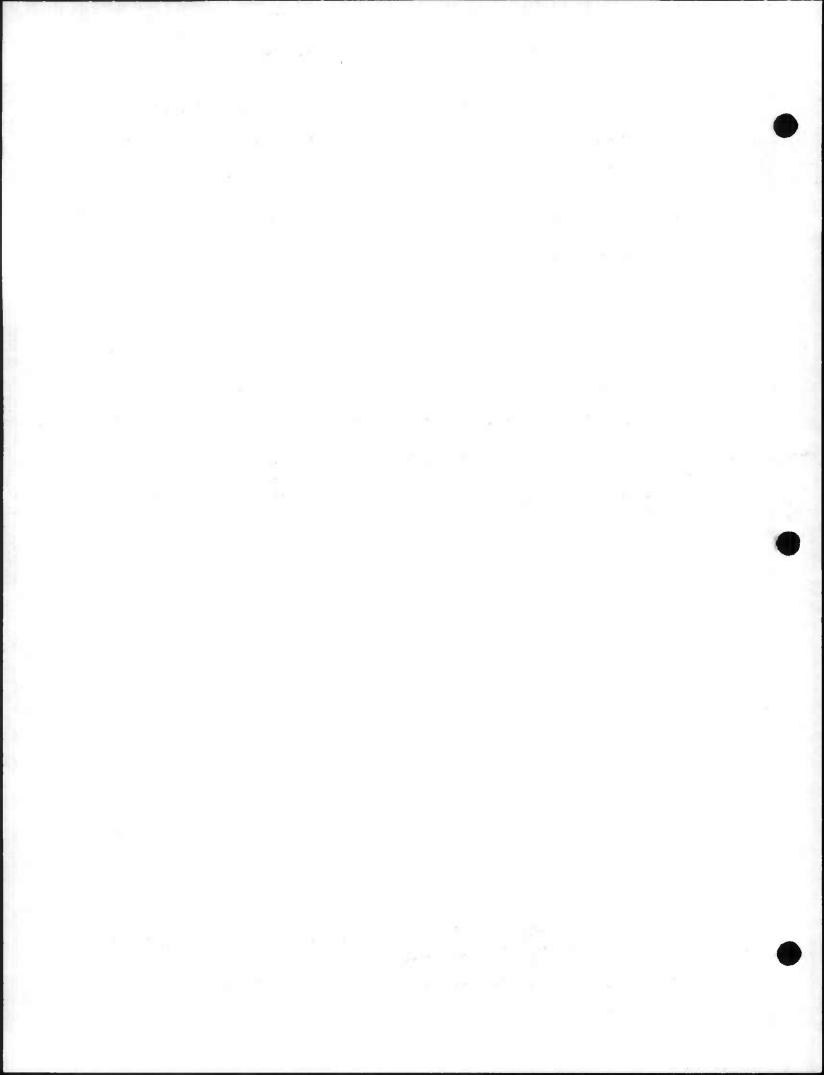
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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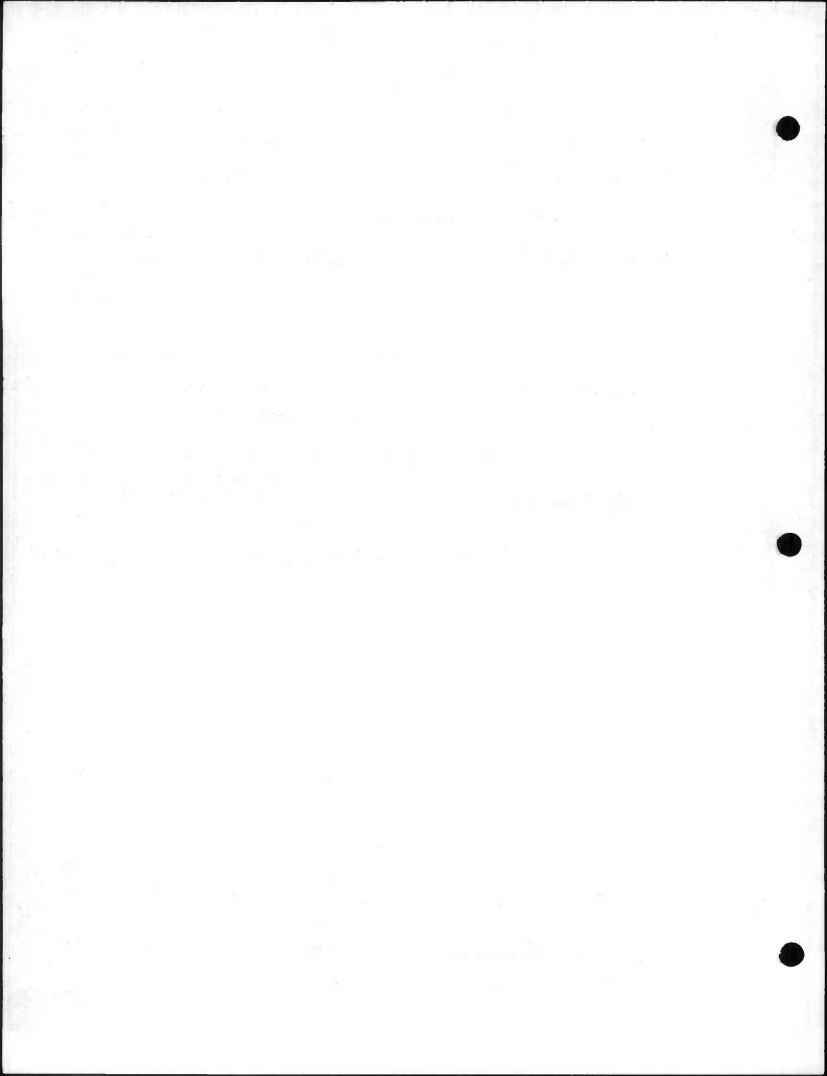
State of Maryland / Department of Health and Mental Hygiene

4834 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month April 28, 12:40 p.m. 1997 Nancy Otis Lyon /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3705 Curtis Court Chevy Chase Montgomery Hours Min. 8. Data of Birth (Month, Day, Year) Feb. 18, 1924 If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1□M 2KF Yrs. Director 73 Illinois 339.24.3705 Usual Rasidance of Decedant permit. Peges 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Health and Mentel Hyglene. Important: if them 23 is marked other than "natural", or items 23s or 28s-f show any injury or other traumstic avent 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Montgomery Chevy Chase 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 3705 Curtis Court 20815 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 █ No 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2X No Specify: White þ 3€Widowad 4 Divorced Specify: Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) +4 Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Surnama) Be Laurence Otis Wilson Mary Faith McAdoo 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2299 Pearl Street #208 Boulder, Colorado 80302 Peter Lyon 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ABurial 2 Cramation 3 Ramoval from Stata Rock Creek Cemetery 5/5/97 Washington D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W. WDC 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Approximata Intarvsi Batwe Onsat and Daath **Physician** /Medical Immediata Causa (Final Metastatic Brain Tumor 2 months disaasa or condition rasulting in daath) Examiner Dua to (or as a consaquanca of). 15 Years Examiner Breast Cancer requires that the death certificate be executed buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Diseasa or Injury that initiated avants rasulting in daath) Last end Dua to (or as a consequence of): physician s the buriel Records, P.O. Box 68760. Physician/Medical Dua to (or as a consaguance of): 80 ettending i USB signed by the el Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown Pulmonary Emphysema þ 24b. Wara autopsy findings available prior to page 2 should Completed 24a. Was an autopsy performad? peen complation of causa of death? The law certificate hes 1 Yas 2√ No 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was casa rafarrad to madical 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 10 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding invastigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examinar: On the basis of axemination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Cartifiar Medical 29b. Signatura and titla of certifiar 29c. Licansa numbar 29d. Data signed (Month, Day, Year) April 29, 1997 DC 6104 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Thomas Havell, M.D. 4201 Cathedral Ave. N.W. Washington D.C. 32. Ragistrar spignature. 31. Data fitad (Month, Day, Year) State MAY Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 14835 Certificate of Death 1. Decedant's Nama (First Middle Lest) 2. Data of Daath 3. Tima of Daath **Physician** Month Day Yaar Pearl Ellen Lehto April 28, 1997 9:00 AM /Medical 4a. Facility Nama (If not Institution, giva street and numbar) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Silver Spring Holy Cross Hospital Montgomery If Under 1 Year Birthpiaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Deys Hours Min. 1□M 2▼F Yrs. 034-16-5574 75 Oct. 15, 1921 Massachusetts Usual Rasidance of Decadant 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Maryland Montgomery Silver Spring 10e. Straat end Number 10g. Citizen of What Country? 10f. Zip Coda Funeral U.S.A.

14. Raca - Amarican Indian,
Black, Whita, atc. 1007 Laredo Road 20901 12. Wes Decedant Evar in U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Yas 2 No if Yas, Giva Yaar or Datas: 1 Navar Married 27 Marriad 1 ☐ Yes 2 ▼ No by Specify: 3 Widowed 4 Divorced White Completed 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highast grada completed) Elementery/Sacondary (0-12) Collega (1-4or 5+) Divisional Coordinator Medical 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Be Top Alfonse Paulsen Helen Koenig 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. informant's Name/Raiationship (Type, Print) George V. Lehto 1007 Laredo Road Silver Spring, Maryland 20901 20b. Place of Disposition (Nama of camatery, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Steta 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) Metropolitan Crematory 4/30/97 Alexandria, Virginia 21. Signatura of Funeral Sarvice Licansaa 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 23a. Part1. Entar tha disaasa, or complications that Cased the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest,

Approximate

Approximate Approximata Interval Batween Onsat and Death Immadiate Causa (Final disaasa or condition rasulting in death) ACUTE MYOCARDIAL INFARCTION Examiner Sequentially list conditions, if any, laading to Immadiata ceuse. Entar Undarlying Ceusa (Disaasa or injury thet initiated avants resulting In daath) Last Due to (or as a consequence of): Physician/Medicai Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 20 No 1 Yas 1 Yas 2 No 25. Was cese refarred to medicel examiner? Be 26. Plece of Deeth (Check only one) 1□ Yas 2X No Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) ٩ 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Manner of Daath 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 28b. Tima of 1 Naturei 2 Accidant 5 Panding Investigation 1 ☐ Yas 2 ☐ No 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 29a. Certifier 🔀 Cartifying Physician: To tha best of my knowledge, deeth occurred et tha tima, data and place, and dua to tha causa(s) and mannar as stated. Medical (Check only 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29d. Data signad (Month, Day, Year) erson who complated causa of death (Itam 23a) (Typa, Print) 2309 SHOREFIELD ROM WHEATON

The law requires that the death certificets be assecuted Box 68760, P.O. Division of Vital Records, i or Attending Physician: 1 offar death.
Director: After this cartifica Hospital

Funeral

Director

rel', or items 23e or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Heelth and Mantal Hygiene. Important: If Item 27 is marked other than "naturel", or Hems 23 eny Injury or other traumatic event, the Medical Examiner materials.

Physician /Medical

Examiner

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State Registrar

32. Registrar's Signature 01

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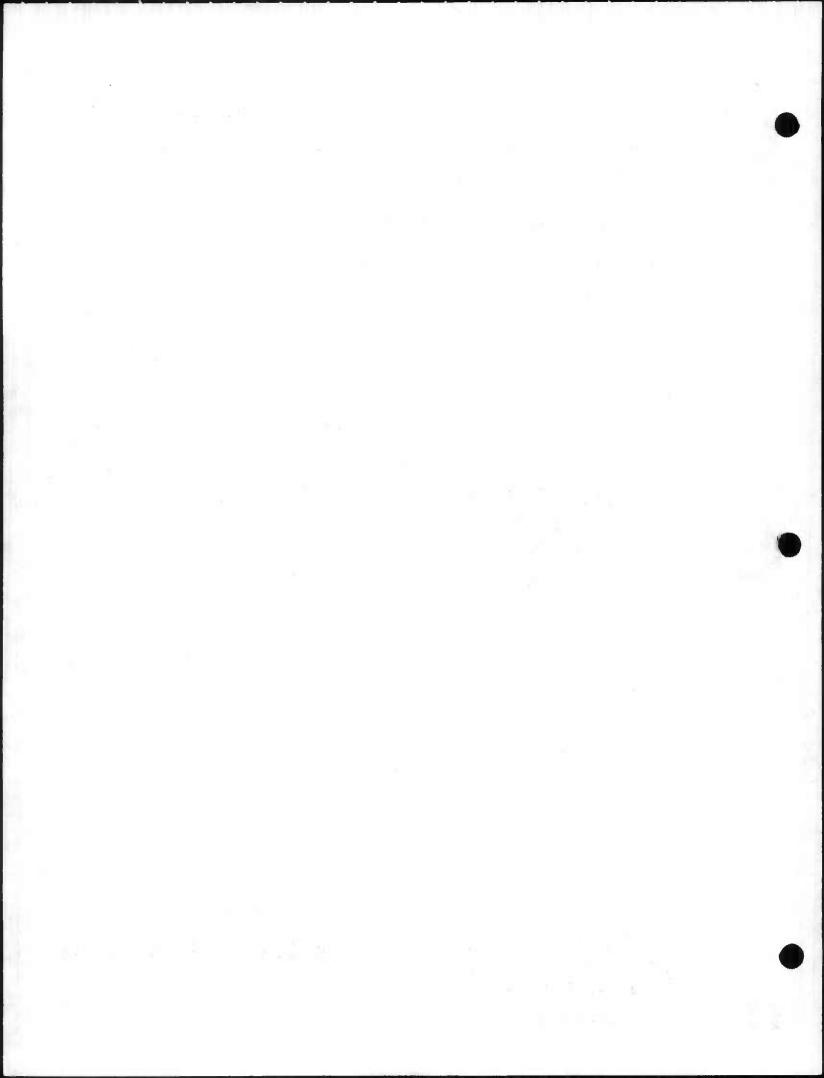
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п	Physic	an	Decedant's Name		st)					2. Date of Dea	Day	Yaar	3. Tima of Death
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4	Examir	er	4a. Facility Name (II			•			4b. City, Town, or Location of Death 4c. County of Death				
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L	Funeral Director		318-32-0593 1□ M 2⊠ F 63 Yrs. Months D Usual Residence of Decedent						Hours Min.	h, Year)	Counti	ace (State or Foreign ry) .a	
	/land		10a. State	10b. County		10c. City, To	own or Location	on				10d. Inside City Limits	
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120	permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Depertment of Health end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, if a Medical Evant not must be notified at once.	by Funeral	11. Marital Status 1 ☐ Nevar Marrie 3 ☐ Widowed		12. Was Decadan Armed Forces 1 ☑ Yas 2 ☐ If Yes, Give Yaar or Dates:	? No		Decedent of H s, specify Cuba Yes 2⊠ No	lispanic Origin? (Span, Mexican, Puerto Spacify:	Specify:			
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Maryland 21215-0020	el Hy of hy vent		17. Fathar's Name (First, Middle, Last)					18. Mother's Nan	na (First, Middle,	Maidan Sumema		
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Baltimore,	t of the or of or of			Cremation 3 🗆	Ramoval from State	cema	e of Disposition stary, cremetor	ry or other plea		Date	20c. Location - 0	City or Tow	n, State
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	Physician /Medical Examiner	ner	Immediate Cause (I disease or condition rasulting in deeth)		. Acuk							-	intarvai Batwaen Onset end Deeth
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,	.4	-	30. Name and address	is of person who o	ompleted cause of	leath (Item 22	a) (Type Print)));;	35261 Internation		. ibi.il	as,	1117
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended # 10e, 19b, 5/2/97, JW, Mont.Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month Beatrice Gladstone Lachman April 22 1997 3:20 A.M. 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dey, Year) 1 M 2 XF Days Hours 158 01 1419 92 Yrs. Dec. 18, 1904 New York Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6100 Robinwood Road 20817 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ff Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coleman Company Elementary/Secondary (0-12) College (1-4or 5+) of Manhattan 12 Grain Broker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Adolf Gladstone Jennie Stark 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 610119a. Informant's Name/Relationship (Type, Print) Judith Strauch 6100 Robinwood Road Bethesda, Maryland 20817 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1X Burial 2 ☐ Cremation 3. Removal from State 4 Donation 5 Other (Specify) 04/24/97 Washington, D.C. Adas Israel Cemetery 21. Signature of Funeral Service 22. Name end Address of Facility Ives Pearson Funeral Homes 2847 Wilson Blvd, Arlington, Enter the disease or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or learn feiture. List only one cause on each line. VA 22201 Approximate Intervat Between Onset and Death Acute myoraro Imm Take Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Mo-sclerons Due to (or as e consequence of): 23b. Did tobacco use contributa to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to 24a. Was en eutopsy performed?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

nd 2 should be filed within 72 hours after death it and Mentel Hygiene. 23 F Is marked other than "naturst", or items 23, traumstie event, the Medice Experient manners.

permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Itam 27 is marked other any Injury or other traumatic event

Baltimore, Maryland 21215-0020

Director

Funeral

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Examiner Physician/Medical 98 þ Completed director, Be 2

The law requires that the death certificate be axecuted

Attending

Division of Vital Records, P.O. Box 68760,

physician end s the burief-transit signed by the a certificate After this Certification: daath. filled in by the f the Hospital or Att thin 24 hours efter d the Funeral Direct To the Hospital of within 24 hours elemental D completely filled

Part II. Other significant conditions contributing to death but not resulting in the underlying cause, given in Part I.

1 Inpatient

1 Yes 2 No

completion of cause of death? 1 Yes 2 No

28. Place of Deeth (Check only one) 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

28e. Dete of Injury (Month, Dey Year) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29b. Signature and title of perti

5 Pending

Investigation

6 Could not be determined

25. Was case referred to medical

31. Date filed (Month, Dev. Year)

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident 3 ☐ Suicide

4 Homicide

29a. Certifier

29c. License number

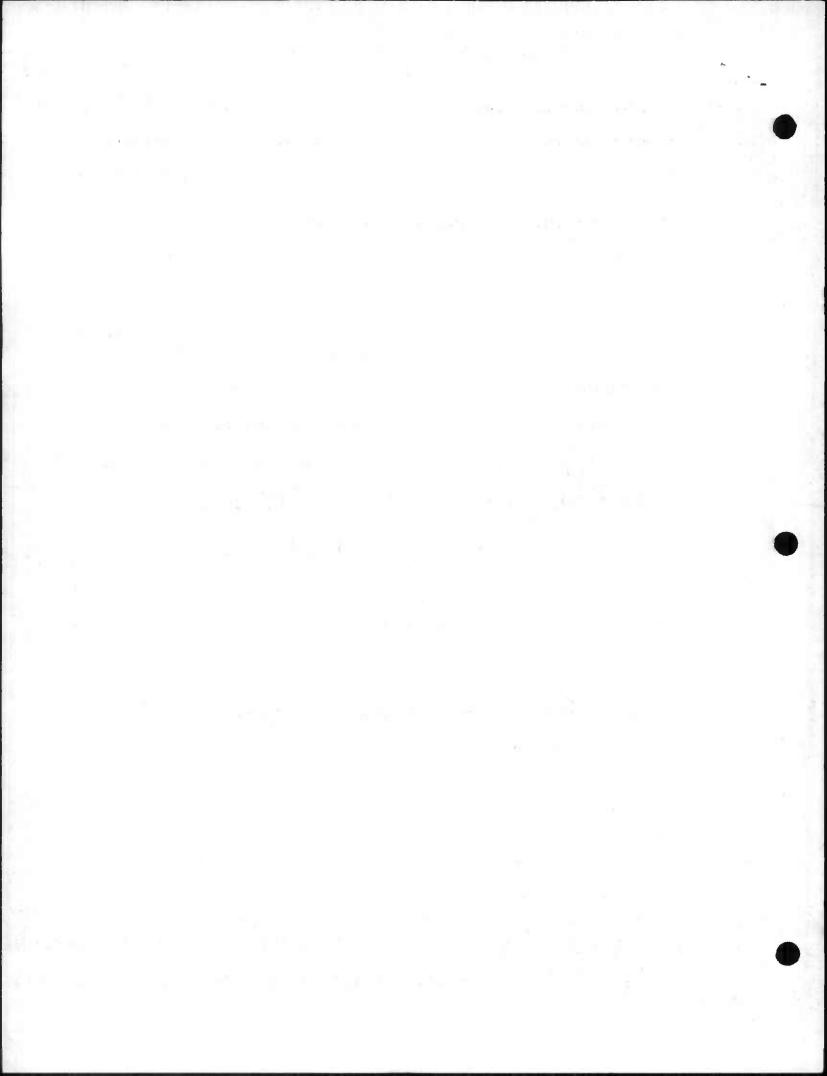
29d. Date signed (Month, Day, Year)

rson who completed cause of death (ttem 23a) (Type, Print) ocer

10401 DO Georgetown Rd, Betherda Leonard mi 32. Registrates Signature

State Registrar

Medicai



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month May **Physician** Grace P. Van Leer 1997 2125 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Union Hospital Elkton Cecil If Under 1 Yaar Months Deys 5. Social Security Number 7. Age (In vrs. lest birthdey) 6. Deta of Birth OCL. 9, 1913 Birthpiece (State or Foreign Pountry)
 Pa if Undar 24 Hrs. **Funeral** Hours 1 □ M 2801 178-07-5254 Vrs Director Usuel Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yas 2 ☑ No Md. Cecil Earlville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 265 21919 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indien, Bleck, White, etc. 11. Meritei Stetus 1 ☐ Yes 2√ No If Yes, Give Yaar or Detes: 1 ☐ Never Married 2 ☐ Married White 1□ Yes 2□ No by 3 ☐ Widowed 4 💆 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Clerk Retail 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Surnama) Be 2 Archibald C. Pennell Florence Poore 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) John B. Van Leer P.O. Box 265, Earlville, Md. 21919 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removel from State 5-6-97 4 ☐ Donation 5 ☐ Othar (Specify) Media Cemetery Media, Pa. 21. Signature of Funeral Service Licens 22. Neme end Addrass of Facility R.T. Foard Funeral Home, P.A. 318 George St., Chesapeake City, Md. 21915 , or complicetions thet caused the daeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, List only one ceuse on each line. Approximata Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel diseese or condition rasulting in deeth) 1 YOCARDIAL INFARC Examiner Due to (or es a consequença of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initioled events resulting in death) Last Due to (or es e consequence of) Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were eutopsy findings available prior to completion of causa of deeth? 24a. Wes en autopsy performed? Completed 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 28. Pleca of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth Certification: 28b. Tima of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 3 Suicide 6 Could not be determined Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 - Homicide edicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) and menner as steted. 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the fime, date and place, end due to the cause(s) end manner stated. 29b. Signature and title of certified 29c. Licansa number 29d. Deta signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) Greve M.D. P.O. Box 670 Rt. 213 So. Cecilton, Maryland 21913 Patricia A. 32. Reflistrar's Signature State

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Registrar

permit. Pages 1 and 2 should be filled within 72 hours after death with the Manyland Department of Heath and Mental Hygiene. Important: if flem 27 is marked other than "natural", or flems 28 or 28s-f show any injury or other treumetic event, the Medical Examiner mass he notified.

signed by the attanding physician and 1 be datached for use as the burial-transit

been si should

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cartificata

the Hospital or Attending Physicien: nin 24 hours after death. the Funeral Director: After this cartifica pletely filled in by the funeral director, i

To the Hospital of within 24 hours a To the Funeral D completely filled in

The lew requires that the death certificata be executed

Division of Vital Records, P.O. Box 68760,

Baitimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day **Physician** Eileen Elizabeth Lee April 25, 1997 6:00 am /Medicai 4b. City, Town, or Location of Deeth 4e. Facility Name (If not institution, give street end number) **Examiner** 4c. County of Death Gladys N. Spellman Nursing Center Cheverly Prince George's If Under 1 Yeer If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Aug. 22, 1 **Funeral** Birthplace (State or Foreign Country) 216-44-3582 1□ M 2⊠ F 89 Yrs. Director 1907 Indiana Usual Residenca of Decadent with the Maryland 10a State 10b. County show 10c. City. Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Prince George's Director Mt. Rainier 1⊠ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4049 34th Street 20712 U.S.A. Funerai death 11. Marital Stetus 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14 Raca - American Indian permit. Peges 1 and 2 should be filed within 72 hours effer a Department of Healin and Mental Hygiene. Important: If Item 27 is merked other than "natural", or iter any Injury or other traumatic event. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: by Specify: 3 X Widowed 4 ☐ Divorced Yeer or Dates: White Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Elementary/Secondary (0-12) College (1-4or 5+) Financial Officer 12 Agriculture 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas T. Flynn Adelade Jones 2 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Lee / Step-Son P.O. Box 86, Boston, Virginia 22713 Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 4/28/97 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis Gasch's Sons Funeral Home, P.A. 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner The law requires that the deeth certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last pue burial-tran Due to (or as a consequence of) Box 68760, ettending physiclan Physician/Medical the Due to (or as e consequence of): P.O. I n signed by the et Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? certificate hes 2.27 No 1 Yes 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28e. Date of injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 Could not be determined 3 Sulcide 3 Place of Injury - At home, farm, atreet, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 D Homicide within 24 hours e To the Funeral C 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, end due to the cause(s) and manner es steted.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only onel \$ 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sam Tellawi, M.D. 7700 Old Branch Avenue #B-102, Clinton, Maryland 20735-1629 31. Date filed (Month, Day, Year) Registrar's Signatur State APR 28 1997

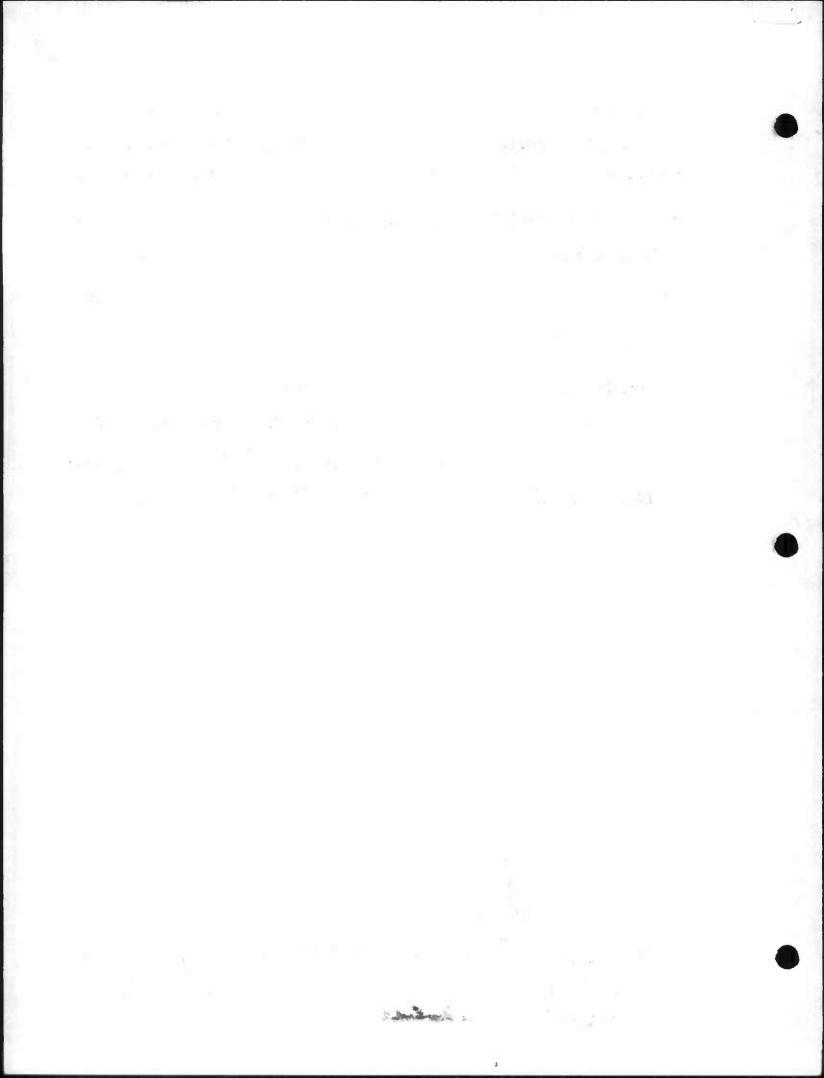
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

AMEN	NDED	#	26.PER DOCTOR P.G.C. 4-30 Decedent's Nama (First, Middle, Last)	•	•	ficate of	Death		Reg. No.	7 1	4840
	hysicia /Medic	al	CAROLYN LEE	- 6 - 1			Ab Ciby Town or b	2. Data of De Month APRIL	Day 21, 19	Year 97 6	3. Time of Death : 37 PM
Fu	examin uneral rector	er	ia. Facility Nama (If not institution, give street and nur FORT WASHINGTON HOSPITA: 5. Social Security Number 6. Sax 433-86-3564		A. A.	If Undar 1 Yaar Months Days		NGTON	, , , , , , , , , , , , , , , , , , , ,	CE GEO	a (Stata or Foreign
	r 28a-f show	tor	Jsual Rasidance of Decedant IOa. Stata 10b. County Maryland Prince George	10c. City	Town or Locat			, agus	27,01		. Inelda City Limits 1∑ Yas 2□ No
th with the	ems 23a or 28 at rough be not	al Director	310 Lourdes Drive			10f. Zip Coda 2074	4		10g. Citizan of V		?
Ind 21215-0020 be filed within 72 hours aftar death with the Maryland tal Hygiena.	or h	by Funeral	11. Marital Status 1 ☑ Navar Married 2 ☐ Married 1 ☑ Widowed 4 ☐ Divorced 1 ☐ Vas. Giv. Yaar or Divorced	2⊠No a		s Decedant of I as, specify Cub Yas 2 X No	Hispanic Origin? (Spean, Maxican, Puarto Specify:	ecify Yas or No Rican, atc.)	14. Rac Blac Specify	e - Amarican ok, Whita, atc y: Blac	
Maryland 21215-0020 of 2 should be filled within 72 hours aff in and Mental Hygiena.	the Medical Ex	Completed	15. Decedant's Education (Specify only highast grada complated) Elamentary/Secondary (0-12) Collaga (1	-4or 5+)	IIIa. DO	it's Usual Occup d of work dona NOT usa retire Maker	pation during most of work d)	ing	16b. KInd of Bi		try
	d othe	To Be C	7. Father's Nama (First, Middla, Last) Roosevelt Lee, Sr.				18. Mothar's Name Rachel	Robins		na)	
, Marylar and 2 should be	27 is marke or traumatic		19a. Informant's Name/Ralationship (Type, Print) Joseph Lee/Son		_	-	Dr., Fort				
Baltimore, M. permit. Peges 1 and 2. Department of Health a	int: If item iry or oth		0a. Mathod of Disposition 1 ⊠ Burial 2 □ Cramation 3 □ Removsl from 9 4 □ Donation 5 □ Othar (Specify)	Stata	ace of Dispositi matery, cramate	ory or other pla		04726 1997	20c. Location -		
Balt Permit. Departr	eny Inje		Nancy A Percent		J.		ass of Facility KINS FUNE over Road		E		
/Me Exar	physician and strength and stre	Examiner	23a. Part1. Entar tha disease, or complications that conshock, or heart failura. List only one cause on a simmediate Causa (Final disease or condition resulting in death) Sequentially list conditions, and, leading to immediate	ordion Dua to (or pserter	as a consequal	effer nca of):	ng, such as cardiac o	or raspiratory a	rrest,	Ay In	oproximata tarval Between nset and Death
- E	g physicia as the bur	edicai	Sequentially list conditions, f any, leading to immediate acuse. Enter Undarlying Couse (Disease or Injury hat Initiated avants resulting in death) Last	Dua to (or	ss a consequar	nce of):				1	
P.O.	echec	Phy	Part II. Other significant conditions contributing to de	ath but not rasu	iting in tha unda	arlying causa gi	van in Part I.	23b. Did	1	ntribute to th	e cause of death?
ecords,	should be	Completed by						24a. Was	an autopsy rmed?	avalla	eutopsy findings ible prior to letion of causa ath?
Ital Ro		Be Com	25. Was casa rafarred to medical				26. Pleca of Deeth	1 Check only		1 🗆 Y	as 2□ No
Division of or Attending Physitier death.	트루	2	axaminer? 1 Yas 24 No Hospitel: 1 In In In In In In In In In In In In In	at (Specify) red er or Rural R	louta Number,						
Ne Hospital	oletaly fills	edicai	29a. Certifier 12 Certifying Physician: To the (Check only one) 2 Medical Examiner: On the band mann	sis of axamination	riedga, daath oo on and/or invas	ccurred at tha ti tigation, in my o	ma, date and placa, opinion, daath occurr	and dua to tha ed at tha tima,	causa(s) and ma data and place,	annar as state and dua to th	od. a cause(a)
To the	comp	2	9b. Signatura and titia of certifier 0. Nama and addrass of parson who completed caus:	len,	MO.	29c. Licans	\$ 864		April	d (Month, Day	v, Year) 1997
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State of Maryland / Department of Health and Mental Hygiene 4841 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** April 15, 1997 0900 Charles Henderson Lynn /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1019 58th Avenue Fairmount Heights Prince George's If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 8. Dete of Birth July 25, 1904 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Mary Land **Funeral** XXM 2□ F 92 Yrs 578-14-6536 Director Usuel Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-f ahow trsumstic event, the Moutosi Examiner must be notified at Mary land Fairmount Heights Prince George's Yes 2□No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20743 U.S.A. 1019 58th Avenue Funeral 11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. filed within 72 hours after of Hygiene. ther than "netural", or Rei 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No by Specify: Black 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Milkman Sealtest (Dairy) 8th grade permit. Peges 1 and 2 should be file Department of Health and Mental Hy, Important: If Nem 27 is marked othe any Injury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be Alice Diggs Charles H. Lynn, Sr. 2 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1019 58th Avenue Fairmount Heights, Maryland 20743 19a. informent's Neme/Relationship (Type, Print) Mrs. Dorothy Anna Lynn (Wife) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 4/19/97 Laurel, Maryland Maryland National Park 21. Si neture of Funerei Service Licensee 22. Korrins Funeration, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 Enter the disease, or complications that caused the complete complete complete cause on each line. nplicetions that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, **Physician** Immediete Ceuse (Finel diseese or condition resulting in deeth) /Medical Arteriosclerotic Cardiac Disease Examiner Due to (or es e consequence of): Examiner bunel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest pue Due to (or es a consequence of) that the death certificate be exec Box 68760. physician Physician/Medical the Due to (or es e consequence of) attending 5 P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 X Unknown Division of Vital Records. þ 24a. Wes en eutopsy performed? 24b. Were eutopsy findings evallable prior to completion of cause of deeth? Completed peeu page 2 certificate 1 Yes 2XXN0 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director; After this certifics Be 25. Wes case referred to medical 28. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5XX Residence 6 Other (Specify) 2 1X Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred Medical Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation 1XXNeturel 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, e.c. (Specify) AQ UI 4 Homicide Certify 29a. Certifier ng Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner as stated. Examiner: On the casis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and financer stated. 29b. Signeture end ti 29d. Date signed (Month, Dey, Year) 30. Neme end addres 201

DHMH 16 Rav 6/95

State

Registrar

31. Dete filed (Month, Dey, Yeer) APR 3 0 1997

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Dey LUMPKIN April 26, 1997 1:45 p.m. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** 113 Colton Street Upper Marlboro Prince George's 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1 ☑ M 2 ☐ F Yrs. Director 578-66-1073 43 July 21, 1953 Danville, VA Usual Residence of Decedent tha Maryland 10e State r than "neturel", or items 23a or 28a-f show the Medical Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 □ Yes 2 □ No Maryland Prince George's Upper Marlboro 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Pagas 1 and 2 should be filed within 72 hours after death with nant of Haalth and Mantal Hygiena.

ant: If item 27 is marked other than "neturel", or items 23a or any or other traumatic event, the Medical Examines must be 113 Colton Street 20774 United States 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: 11 Maritel Stetus 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American indien, Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☒ No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced Black Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Public Works Government Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Oliver R. Lumpkin Mary M. Carter 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary M. Lumpkin - Mother 113 Colton Street, Upper Marlboro, MD 20e. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 12 Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Paga Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) 4/30/97 Harmony Memorial Park Landover, Maryland 21. Signature of Equerel Service Licen 22. Neme end Address of Fecility STEWART FUNERAL HOME, Inc. r the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, D. C. Approximete intervel Between Onset end Deeth Physician /Medical Immediete Cause (Finel diseese or condition resulting in deeth) e. Acquired Immune Deficiency Syndrome Examiner Unknown Due to (or es e consequence of): The law requires that the death cartificate be axecuted the burial-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, attanding physician Physician/Medical Due to (or es e consequence of): usa as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Diabetes Mellitus Records. þ 24b. Were eutopsy findings evalleble prior to paga 2 should Completed 24e. Wes en eutopsy performed? peed completion of cause of deeth? Aftar this cartificata 1 Yes 2₺ No 1 ☐ Yes 2 X No Division of Vital Attending Physician: Be 25. Wes case referred to medical 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 ☐ inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28e. Dete of injury (Month, Dey Year) funaral 27. Menner of Deeth Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 X Naturel daath. 1 Yes 2 No spital or Attendi ours after daath heral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be determined 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours Funeral 1☑ Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) and manner as steted.
2☐ Medical Examiner: On the bests of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner steted. 29a. Cartifier To the Hosp within 24 hou To the Fune complately fi Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of death from 23e) (Type, Print) Stepiten JAY Peince George's Hospital mo KATZ 31. Dete filed (Month, Dey, Year) 32 Registrer's Signeture State 30 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth Physician 0:09 A.M. Harry William McCusker /Medical 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Hagerstown If Under 24 Hrs. 8. Deta of Birth Hours Min. (Month, Dey, Year) Washington County Hospital 5. Social Sacurity Number 6. Sax 7. Age Washington If Under 1 Yaar 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** 1 □ M 2 □ F Months Deys Yrs Director 217-30-5641 64 April 4, 1933 MD Usuel Residence of Decedent with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yas 2 XNo Director MD Washington Hancock 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or traumatic event, the Medical Examiner inset be it 3006 Mann Road nit. Pages 1 and 2 should be filed within 72 hours after deeth a artment of Health and Mental Hygiene. ortant: if itam 27 is marked other than "natural", or itams 23. Funerai 21750 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 11. Meritel Stetus 14. Rece - American Indien, Black, Whita, etc. 1 Navar Married 2 Married 1 XYes 2 No If Yes, Give Year or Detas: Maryland 21215-0020 1□ Yes 2□No ρ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Buainess/Industry Elamentery/Secondary (0-12) College (1-4or 5+) 12 Security U.S. Army 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be William McCusker Hazel Munson 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent'a Neme/Reletionship (Type, Print) Shelvy J. McCusker/Wife 3006 Mann Road Hancock, MD 21750 Baltimore, 20b. Plece of Disposition (Neme of cematary, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 X Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Department o important: If i any injury or once. Mt.Olivet Presbyterian 22. Neme end Address of Facility 5/10/97 Hancock, MD 21. Signetura of Funerel Service Licen Grove Funeral Home, P.A. P.O.Box 368 Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line Approximete tntervel Between Onset end Deeth of the death to not antar tha mode of dying, such es cerd Physician teriling /Medical immediete Cause (Finel 050 diseese or condition resulting in deeth) Examiner Due to (or es a consequence of) buriel-transit Sequentielly list conditions, if eny, leeding to immediate ceusa. Enter Underlying Cause (Diseese or injury that Initiated events resulting in deeth) Lest pue Due to (or es e consequence of): physician s the buriel Records, P.O. Box 68760 Physician/Medical Due to (or es a consequence of) esn signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yas 2 ☐ No by 24b. Were autopsy findings eveileble prior to completion of causa of deeth? 24e. Wes en eutopsy parformed? Completed 1 Tes 2 DM 1 ☐ Yes 2 ☐ No certificate of Vital 25. Wea cese referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 Impatient 2 □ ER/Outpetient 3 □ DOA this 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation s after death 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide Hospital or To the Hospital within 24 hours a To the Funeral Completely filled

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(a) end menner ea steted.

cause of deeth (Item 23e) (Type, Print)

Medicat Examinar: On the basis of axeminetion end/or invastigetion, in my opinion, deeth occurred at tha tima, data and place, and dua to the ceusa(s) and manner stated.

tagens

State Registrar

cai

Medi

29a. Certifier

29b. Signatur

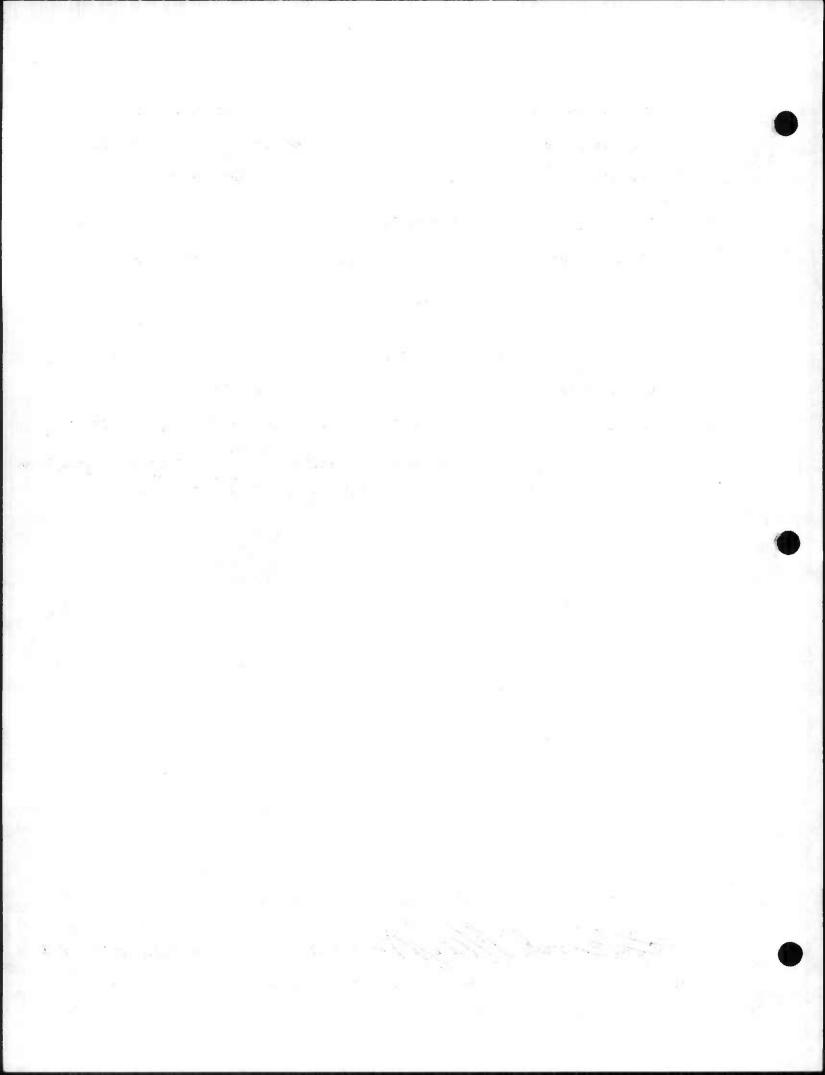
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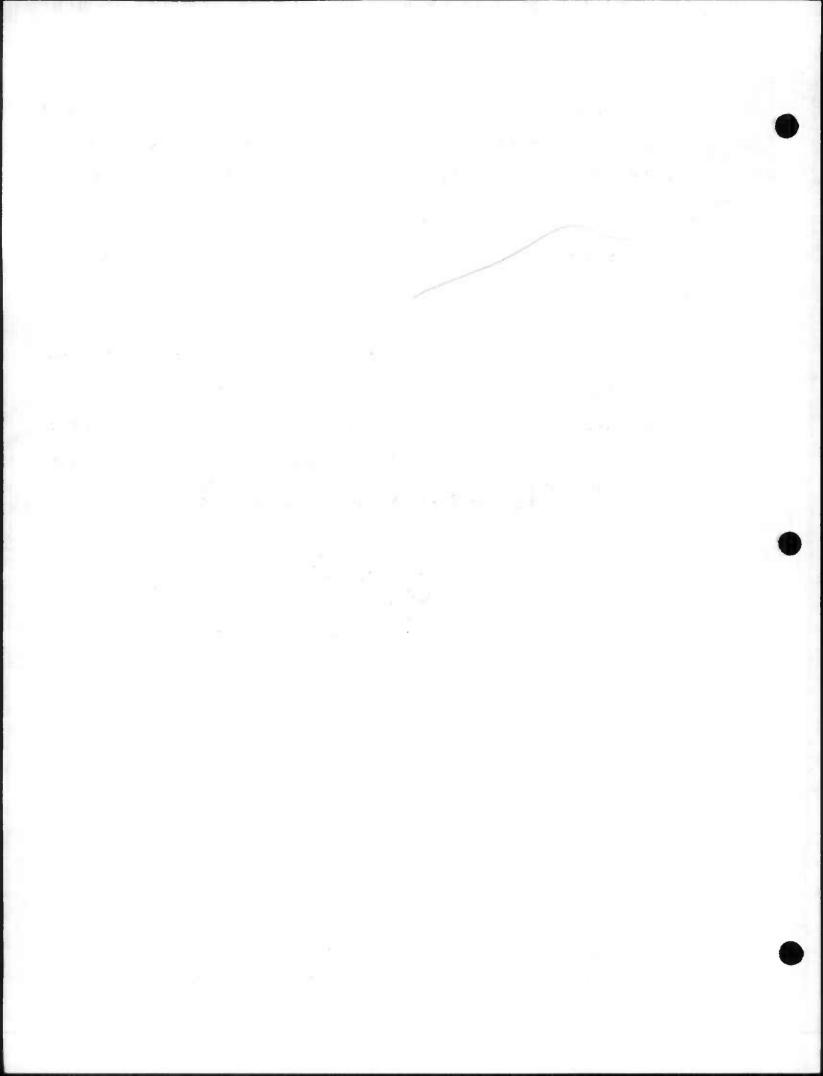
MALESTAN TO THE LIVER

State of Maryland / Department of Health and Mental Hygiene 97 | 4844

						Ce	rtificate	e of	Deatl	7		Reg. N	0.			
п	D 1		1. Decedent's Name (First, Middla, L	ast)							2. Data of D			V	3. Tima of Death	
	Physic /Medi		Matthew J. McCan	ctin							April		199	Year 7	4:41AM	
	Exami		4a. Facility Name (If not Institution, g	ive street and nur	n <i>ber)</i>				4b. City, T	own, or L	ocation of Dea			of Death	-11-11111	
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Н	Funeral	Г			7. Age (In yrs. la	st birthday			if Unde	r 24 Hrs.	8. Date of B	irth			4	
	Director		070-18-4859	1 ∑ M 2□ F	73	Yrs.	Months	Days	Hours	Min.	June	ay, Year			place (Stata or Foreign htry) York	
	B		Usual Residence of Decedent								June	219I	723	MEM	TOLK	
	show		10a. State 10b. County		10c. City,	Town or L	ocation							1	0d. fnside City Limits	
	Mar	to	Maryland Montgome	erv	Roc	kvil.	l e								1 ¥Yas 2 No	
	r 284	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of	What Cour	ntry?	
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	Jeath Trs 2	Funeral	633 Blossom Drive	12. Was Dece	dent Ever in U,S	. 13.				rigin? (Sp	ecify Yes or N			e · Americ		
0	fter dea	E	1 ☐ Never Married ŽČXMarried	Armed For	rces? 2□No Wor	World If Yes, specify Cuban, Mexicen, Puerto R					Rican, etc.)	Rican, etc.) Black, White,			etc.	
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0	in 72 hours after death with the Maryland "netural", or items 23s or 28e-f show teoical Experience must be notified at	8	15. Decedent's E	Education		16a. Dece	dent's Usua	I Occu	pation			16b. I	Kind of B	usinass/In		
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21	d within piene. r than "	Completed	Elementary/Secondary (0-12)	College (1	-40r 5+)	Att	torney	7				II.	S. G	overr	nment	
D	등 늦음 된	Be C	17. Father's Nama (First, Middle, Las				<u> </u>	-	18. Moth	ner's Nam	e (First, Middle					
a		ToB	Matthew McCartin						Cat	heri	ne Dol	an				
ary		-	19a. Informant's Name/Ralationship	(Type, Print)		19b. Maili	ng Addrass	(Stree			al Route Num		or Town	Stata. Zio	Coda)	
Z	755		Jane R. McCartin								kville				20850	
ē,			20a. Method of Disposition	WILE	20b. Pla							Ť	- 10	City or To		
2	00-		1X Burial 2 ☐ Cremation 3		State	metery, cre	osition (Nam	ther pla	April	L 29,	1997					
altimore, Maryland 21215-0020	그두후루		4 ☐Donation 5 ☐ Other (Spec	-	Gate	= 01 1	neaven	I Ce	illete!	LY		Sil	ver	Sprin	ng,Maryland neral Home,	
Ba	Departr Departr Importa any Inju		Turing Service Lice	13												
			Rockville, Inc. 300 West Montgomery Avenue M00803 Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that guised the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, interval Between Interval Between													
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that d y one cause on e	sused tha daath. ich lina.	Do not en	tar tha mode	e of dy	ing, such a	s cerdiac	or respiratory	arrest,		t	Approximate Interval Between	
1	Physician														Onset and Death	
	/Medical Examiner		Immediate Cause (Final disaase or condition	Acu	te Myoca	ardia	l Infa	arct	ion							
п	LAGITITIE		resulting In death)	a	Due to (or	as a conse	quence of):							- (
-	led sit	ine		Art	erioscle	eroti	c Card	liov	ascu.	lar I	isease			i		
	certificate be executed Iding physician and Ise es the bunal-transit	Examiner	Sequentially list conditions,	D	Due to (or	as a conse	quenca of):							<u> </u>	111111111111111111111111111111111111111	
68760,	e ex	E I	Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Dua to (or as a consequence of):													
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	that the death hed by the etter detached for u	Physician	Part II. Other significant conditions	contributing to de	ath but not result	ing in tha u	nderlying ca	use gi	ven in Part	I. T.	23b. Did	tobacc	o uss co	ntribute to	the cause of death?	
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Re	0 5 0	Completed											. 171			
Ö			OF Was once referred to medical										No No	11	Yes 201 No	
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\(\bar{\pi} \)	or A Direct	Į.	4 ☐ Homicide datarmined	buildin	of Injury - At hom g, atc. (Specify)	ia, iami, sti	aat, factory,	onice			City or To			er or Hura	I Route Number,	
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	within 2 To the comple	Med	une)	and mann	er stated.	-		-						WW		
	5 ₹ 5 8		29b. Signatura and title of certain	6	1///	>	290.	Licens	se number			29d. Da	ate signe	d (Month, I	Day, Year)	
	8+1		TOPECE	W/	111	1		070)99			MP	RIL	2	7 97	
		1	30. Name and address of person who	completed causa	of death (Item 2	(Type,	Print)									
			Francis C. Mayle	, M.D.	10215 F	ernwo	od Roa	ad,	#301	, Bet	hesda,	Mar	ylan	d 20	0817	
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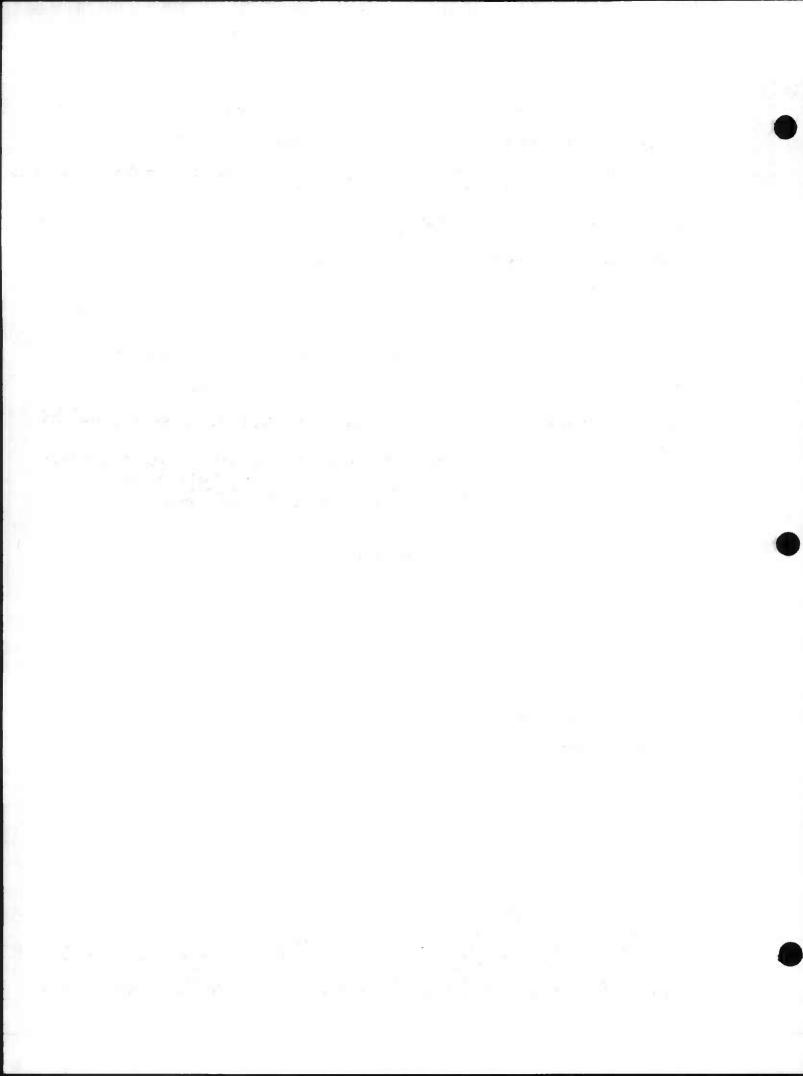
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	Dhambalai		1. Decedent's Neme (First, Middle, Last)					2. Dete of De		Voor	3. Time of Death
	Physici /Medi		Ella Sue	Minor				April	Day 22, 1	Year 997	10:35 P.M.
	Examir		4a. Fecility Name (If not institution, give street a	and number)			b. City, Town,	or Location of Deeth		of Deeth	
1			Manor Care of Chevy (Chase			Chevy	Chase	Mont	gomer	·v
	Funeral		5. Sociel Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Devs	If Under 24 H		th	Aud	ace (State or Foreign
	Director		216-44-3023 ^{1□ M 2}	93	Yrs.	WOILIS Doys	Tiours IV	Feb. 1	1904	Geor	
	pud *		Usual Residence of Decedent 10a. State 10b. County	100 City	Town or Loc	nation				40	11.11.00.11.0
	sho	2	6. 46.	,						10	d. Inside City Limits 1X Yes 2 □ No
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	with with	ā							10g. Citizen of W		
	1 23 ma 23	era	3616 Littledale Road 11. Marital Stetus 12. Wa	s Decedent Ever in U.S.	13 W	2089 S		(Specify Ves or No	United	State - America	
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21		no.	, ()	5+	Sta	atisticia	an		Federa1	Gove	ernment
nd	m - 0 =	0	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Meiden Sumame	e)	
yla	should be find Mentel I marked of	P	William Ar	thur Mino	r			Mattie	Wood		
Mar	2 sh end is m		19a. Informant's Name/Relationship (Type, Prin	nt)	19b. Mailing	g Address (Street	and Number or	Rural Route Number	er, City or Town, S	State, Zip C	Code)
	it. Pages 1 end 2 should be siment of Heelth end Mente wrant: If Item 27 is merked injury or other treumatic ev		Robert Minor/Nephew				Street	Chevy C			
Ore	F Itel		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Remova		ce of Dispos n <i>etery, crem</i>	ition (Name of atory or other pled	ce)	Date	20c. Location - (City or Tow	n, State
Baltimore,	permit. Pages Depertment of Important: If it any injury or once.		4 ☐ Donetion 5 ☐ Other (Specify)			tan Crem		4/23/97	Alexand	ria,	Virginia
39	Dependent Important Information Informatio	_	21. Signature of Funeral Service Licensee	0 20	22.	Name and Addre	ss of Facility	DeVol Fun	eral Hom	ne .	
7	0 5 4 C		Michael	- Culibra	m 10	East De	er Park	Dr., Gai	thersbur	g, MI	20877
	Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. e on each line.	Do not ente	r the mode of dyin	g, such es card	lac or respiretory a	rest,	1	Approximate Interval Between Onset end Death
	/Medical		Immediate Cause (Finel disease or condition	Bronce	Pre	umonla					hours
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	cate be executed physicien end the buriel-trensit	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying	Due to (or a	as a consequ	ence of):					
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ă	etter of for	cla	Don't II. Other significant and distance and the significant							1	
0	the carbon arched	Physician/Me	Part II. Other significant conditiona contribution	g to death but not resulti	ing in the un	denying cause giv	en in Part I.				the cause of death?
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Vital	Iclan: The certificate rector, peg	Be C	25. Was case referred to medical		-		26. Place of D	eath (Check only o	ne)		
>	Q 50 Z	ToE	examiner? 1 Yes 2 No Hospital	1 ☐ Inpatient 2 ☐ EF	R/Outpatlent	3□ DOA Oth		Home 5 ☐ Resid		r (Specify)	
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	To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1	To the best of my knowle the basis of examination d menner stated.	edge, death n end/or inve	occurred at the tine estigation, in my o	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s) and mar date and place, e	nner as sta ind due to t	ted. he cause(s)
	To the to the com	Σ	29b. Signature and title of certifier	11		29c. Licens			29d. Date signed	1	ay, Year)
	1-		1 Jun /allh	Tusten mi	9	12	3335	ナ	4/23	197	
	4		30. Name and address of person who complete								
			Jonathan L. Musher, M				,# 1045	, Chevy (Chase, M	D. 20	815
	Sta		31. Date filed (Month, Day, Year) APR 2 8 199	32. Registrar's Signetur	9	2.00					
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State of Maryland / Department of Health and Mental Hygiene

Usual Residence of Decedent 10a. Stete 10b. County Maryland Montgo 10e. Street end Number 2141 Briggs Cha 11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 15. Decadent's (Specify only highest of the county o	Tuerke give street end number) naney Road S. Sex 1 1 M 2 F Dimery The street and number) 7. Age (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	or In U,S. 1.	Location Spring 10f. Zip C 2 3. Was Decede If Yes, specifi	Silver S Year If Under 24 Hr Deys Hours Mir ode 0905 nt of Hispenic Origin? (Y Cuban, Mexican, Pue	Location of Death Spring S. 8. Date of Birth Month, Day Sep. 30	3, 1997 4c. County Mont Yea()916 Og. Citizen of V USA 14. Rac	of Deeth gomery 9. Birthplace Country Washing	Time of Death 7:30 AM (State or Foreign ton, D.(
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Immediate Cause (Finel disease or condition resulting in death)	a	d Cardio		ny				set and Deeth
Sequentially list conditions,	b	e to (or as e cons	sequence of):				1	
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30. Name and address of person wh	o completed cause of deap	r(item 23e) (Typ	e, Print)	/	7	U. I.I.		
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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22. Nama and Addrass of Facility Hines-Rinaldi Funera 11800 New Hampshire Avenue Silver Spring, Maryland 20904												
-	+:	Part 1. Enter the disease or co	molications that caused t	he death. Do	not enter the mo	de of dy	no such as ca	rdar or maniral	DOV BOOK	arrest. Approximate		
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	١,	mmodiate Cause /Final									- 1	
ni er	Immediate Cause (Final disease or condition a COR Pulmonale											
100	Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease											
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State of Maryland / Department of Health and Mental Hygiene

14848 Certificate of Death

Physician
/Medical
Examiner

Funeral Director

Director

Funeral

Completed

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the Meryland 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 72 hours efter "W Baltimore, Maryland 21215-0020 permit. Peges 1 end 2 should be filed within: Department of Health end Mental Hygiene. Important: If Itam 27 is marked other than °r any Injury or other traumatic event, the Med

Physician /Medical Examiner

Box 68760 certificate be

Records, P.O.

Division of Vital

sician end buriel-transit Examin physician s the buriel Physician/Medical 88 esn the signed by t þ Completed peen hes certificate or Attending Physician: efter death. Be Certification: To this After this efter death. Director: Aft filled in by within 24 hours el To the Funeral D completely filled I

1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Charles F. Massey April 28, 1997 7:53 am 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 3330 North Leisure World Boulevard #331 S

7. Age (In yrs. lest birthdey) | H Under 1 Yeer |
Months | Deys If Under 24 Hrs. 8. Do Silver Montgomery 8. Dete of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country) 1 ★M 2 F 577-07-9339 90 Jan. 16, 1907 Virginia Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3330 North Leisure World Boulevard #331 20906 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 ☑ No Specify. by 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Promotions Department Gas Light Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) John Wilkin Massey Mary Downs Foster 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3330 North Leisure World Boulevard #331 19e. Informant's Neme/Relationship (Type, Print) Constance P. Massey Silver Spring, Maryland 20906 20b. Plece of Disposition (Name of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete cemetery, cremetory or other place) 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Parklawn Memorial Park 4/30/97 Rockville, Maryland 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Sil.
23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 500 University Blvd., W., Sil. Spr., Maryland 20901 Approximete Intervel Betw Immediete Ceuse (Final ALZHeimer's DIFFASE 5 yerns disease or condition resulting in deeth) Due to (or es e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of) thet initieted events resulting in deeth) Lest Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PARLKINSON'S DISEASE 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? NORMAL PRESSURE HYDROCEPITALUS 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Date of injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide

To the 20

Hospital

State Registrar

a krani

4 - Homicide

(Check only one)

29b. Signeture end title of certifier

29e. Certifier

m.1).

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number D24543

29d. Date signed (Month, Dey, Year) april 29, 1997

28f. Location (Street and Number or Rural Route Number, City or Town, State)

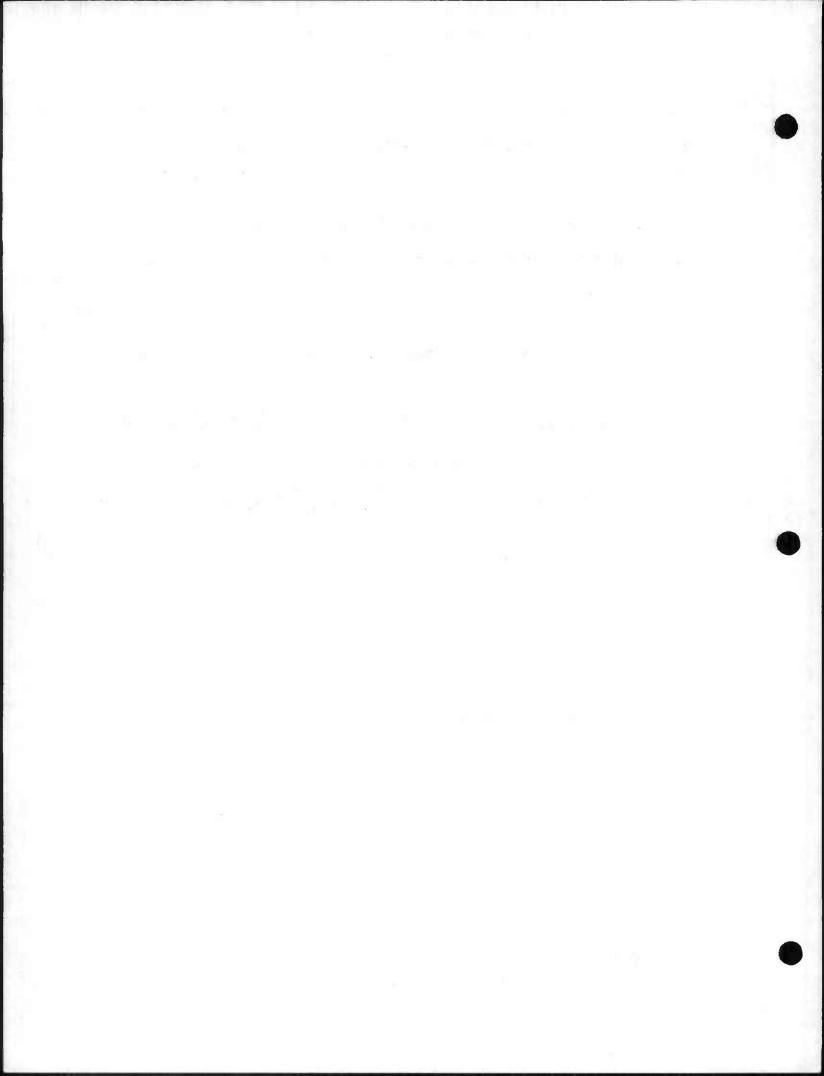
30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

NONTH LEISUN WORLD BUVI), SILVER SPRING, MI) James A. Rossi, mD. 3305

🏂 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as steted.

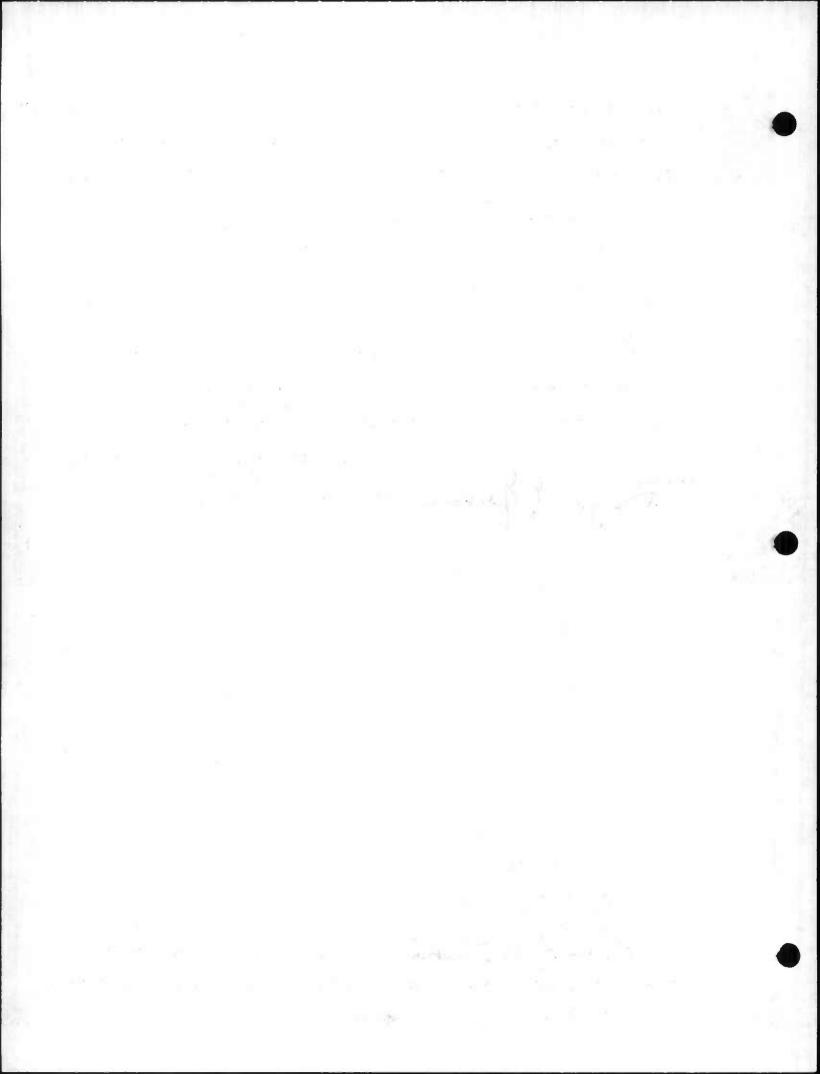
2 Medical Examiner: On the besis of examinetion end/or Investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture
197 Julia Davidson-Randalle MAY 01 1997



						epartment of F Certificate of		, ,	g. No.	7 14849		
	Physic		Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death		
	/Medi		Angelina Abad	Murphy				April 28		9:00 P.M.		
	Exami		4a. Facility Neme (If not institution, give	street and number)			4b. City, Town, or L		4c. County of	Death		
1			6600 23rd Ave.				Hyattsvi:	lle	Princ	ce Georges		
Т	Funeral		5. Social Security Number 6. Se		n yrs. lest birtho	(ay) if Under 1 Year	If Under 24 Hrs.					
	Director		223-54-1066 Usual Residence of Decedent]M 2∕∆F	66 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 2, 19	930 P	Birthplace (State or Foreign Country) hilippines		
	ehow ed at	20	10a. Stete 10b. County		Oc. City, Town o					10d. inside City Limits 1 ☐ Yes 2 🖾 No		
	V 90 0	Sct	Maryland Prince G	eorges	Hyatts					TI THE ZIMINO		
	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show he Mosteal Exemines must be netfred at	ai Director	10e. Street and Number 6600 23rd Ave.			10f. Zip Code 207	782	10	g. Citizen of Wh	nat Country?		
	e	Funerai	11. Maritel Status	12. Wes Decedent Eve	r in U,S.	13. Was Decedent of H	Hispanic Origin? (Sp	ecify Yes or No-		American Indian,		
020	urs after	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowad 4 ☐ Divorcad	Armed Forcas? 1 Yes 2 Voo If Yes, Give Year or Dates:		1 ☐ Yes 2XXIIo	Specify:	nican, etc.)		White, etc. Filipino		
O	2 ho	P	15. Decedent's Edu	cetion	16a. De	ecedent's Usual Occup	pation	1	6b. Kind of Busi	nass/industry		
Maryland 21215-0020	within 7; ane. than "n	Completed	(Specify only highest grad	completed) College (1-4or 5+)	(G	live kind of work done le. DO NOT use retire	during most of work d)	ring				
0	Hygie Hygie ant, p	ŭ	17. Father's Name (First, Middla, Last)		1101	memaker	18. Mother's Nam	o /First Adidate A	Own Hor			
an	d o o	Be		- A				,,	alden Sumame)			
Ž	should be and Mentai marked of umatic eve	10	Aquiline Ab					rimanez				
Ma	12 st h and le n reun		19a. Informant's Name/Relationship (T)			lalling Address (Street				tata, Zip Code)		
	1 end 2 Health em 27 i		John T. Murphy/H			00 23rd Ave	e. Hyatts					
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiane. Important: If item 27 is marked other than any injury or other traumatic event, the Manace.		20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	emoval from State	cametery,	sposition (Nama of crematory or other please National				ity or Town, State Lington, VA		
Balt	Departr Departr Imports any Inju		21. Signature of Funeral Service Licans	9 7 1	,	22. Name and Addre						
			Dya	feele	seh	254 Carro						
			23a. Part1. Enter the disease, or composhock, or heart failure. List only or	e cause on each line.	death. Do not	enter the mode of dyir	ng, such as cerdiac	or respiretory erre	st,	Approximate Intarval Between		
	Physician /Medical		Immediate Court (Flori)	1						Onset and Death		
	Examiner		Immediate Ceuse (Final disease or condition resulting in death)	LUM	Ug	Cance	1			24 mo		
U		-	rooting in douting	Dua	a to obras a con	sequanca of):						
	pe tis	al le										
	ficate be executed g physician and es the bunal-transit	Examiner	Sequentially list conditions,	Due	to (or es a con	sequence of):						
68760,	cian cian buria		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury							14.0		
8	sate the the t	edical	that initiated events rasulting in death) Lest	Due	to (or as e con							
	= 00											
ROX	attending p	an								i		
	the at	Sici	Part II. Other significant conditions con	tributing to death but no	ot resulting in th	e underlying cause giv	en in Pert I.	23b. Did tot	acco use contr	ibute to the cause of death?		
, P.O.	ires that the de signed by the d d be detached	by Physician/M						100	s 2□ No 3	Probably 4 Unknown		
Vital Records,	w requ	Completed b						24a. Wes an perform		24b. Were eutopsy findings available prior to completion of cause of death?		
Ĭ	age h	E	·					1 □ Yes	2.20No	1 ☐ Yes 2 ☐ No		
Ø	iffical		25. Was case referred to medical				26 Place of Doct			70.100 20.100		
>	sicle	o Be	axaminer?	ospital:	a [[[[[[[[[[[[[[[[[[[tiont 3 DOA Oth	er: Deat			(0 4)		
ō	Physician: The le r this carificate has aral director, page 2	. To	27. Manner of Death	28a. Date of Injury	2 ER/Outpe	HIGHT SEL DON	4LI Nuising no	me 5 Rasider 28d. Describe how				
0	Afte fune	tion 1	1 Natural 5 Pending	(Month, Day Ye		y Wor	k? Yes 2 □ No	200. 2000.100 710.	. Injury coouniou			
S	deat deat tor:	Ca	3 Suicide 6 Could not be	One Diego of trium	At home form		/131	204 Leastien (Otr	and and Alumbac	or Pour I Pourto Mountain		
Division of	al or Attending Physician: T s efter death. Il Director: After this cartificat ad in by the funeral director, p	Certification:	4 ☐ Homicide datamined	28e. Place of Injury - building, etc. (S	pecify)	street, factory, office		City or Town,	Stata)	or Rural Route Number,		
_	phtai ours oral filled		29a. Certifiar 1 Certifying Phys	Iclan. To the heat of my	v kasuladas, de	anth assumed at the time	and alone	and due to the sai	(a)			
	To the Hospital or A within 24 hours effer To the Funeral Dire	ledical	(Check only one)	er: On the bast of my erd menner stated.	mination and/or	Investigation, in my o	pinion, deeth occurr	ed et the time, da	te end place, and	d due to the ceuse(s)		
	To To	Σ	29b. Signature end title of certifier			29c. Licens	e number	29	d. Dete signed (Month, Day, Year)		
	15		X aus X	()	1020	. 103	32671	7	pril 28	1. 1997		
			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Typ				-p-11 ac	1 -001		
			Louis F. Diel, M.				orgia Ave	. NW Was	hington	DC 20307		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature							
	Registra	ar	MAY 01 1	397 > Juli	a Davidson	-Randall						

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 14850 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** Apr. ober t 1120 AX 199 /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SHADY GROVE ADVENTIST HOSPITAL Rockville MONTGOMERY If Under 1 Year Months Days 5. Social Security Number 8. Data of Birth (Month, Day, Oct. I, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Hours 1MM 2□F Yrs 220-60-6311 46 1950 Director Maryland Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Medical Examinar must be inclined at Director MD 1X Yas 2 □ No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 727 Monroe Street, #101 20850 U.S.A. permit. Peges 1 and 2 should be filed within 72 hours after death. Deportment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s any Injury or other traumatic event. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, atc ₩ Nevar Marriad 2 Married 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Dalas: Baltimore, Maryland 21215-0020 1 Yas 2 No Black Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Construction llth Laborer 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Robert C. Duvall Anna M. Martin 19a. Informent's Name/Ralationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Anna M. Martin (Mother) 727 Monroe St., #101, Rockville, MD 20850 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Park Cem. 4/29 Rockville, MD 21. Signature of Funeral Service Licerus 22. Nama and Addrass of Facility SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part I. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwas Onset and Dea Physician /Medical Immediata Ceusa (Final disease or condition resulting in death) hom Examiner Dua to (or as a consequence of) Examiner attending physician end for use as the burlel-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceusa (Disaase or Injury that initieted avents rasulting in daath) Last Dua to (or as a consequence of) Box 68760. the death certificate be Physician/Medical Dua to (or as a consequence of): ed by the at detached for Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. PO 23b. Did tobacco usa contributa to the causa of death? signed by t 2 No 3 Probably 4 Unknown Yes Records, by should l 24b. Wara autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed certificata has 21500 1 TYRS 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effar deeth.

To the Funeral Director: After this certifice 25. Was casa rafarred to medical 26. Plece of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To Yas 2□ No 1 Inpaliant 2 PR/Outpatient 3 DOA funeral c 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Naturel 2 Accident 5 Panding 1 Yas 2 No invastigation 6 Could not be datarmined 3 Suicide 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steled.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifia: Medical pletaly 29b. Signature and title of ceptite 29c. License number 29d. Date signed (Month, Day, Year) 2 eginD 30. Nama end eddrass of person complated cause of math (Item 23a) (Type, Print)

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State Registrar edic

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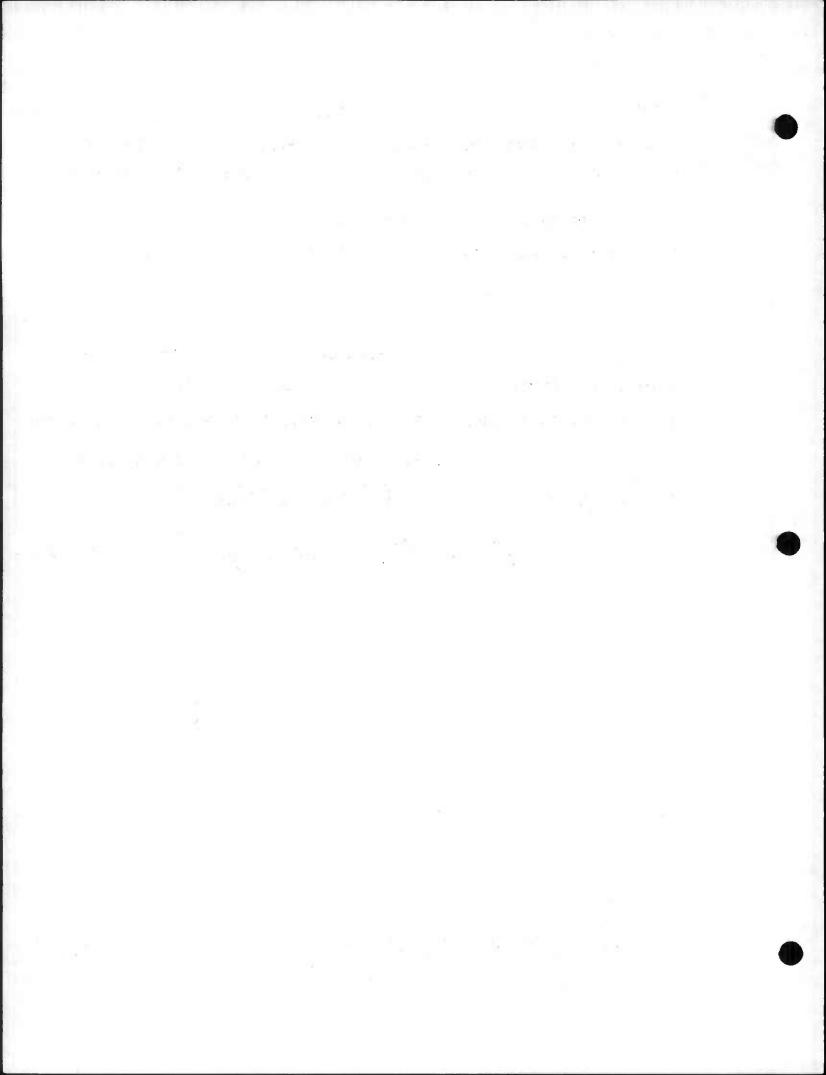
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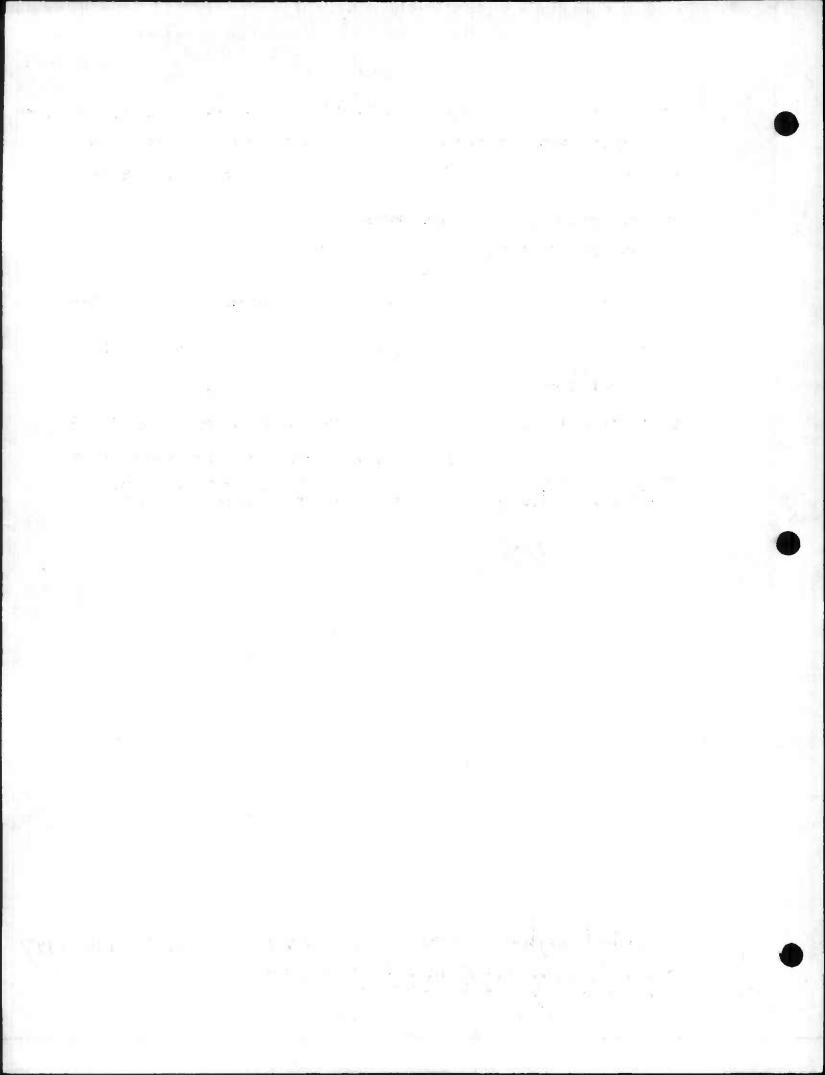
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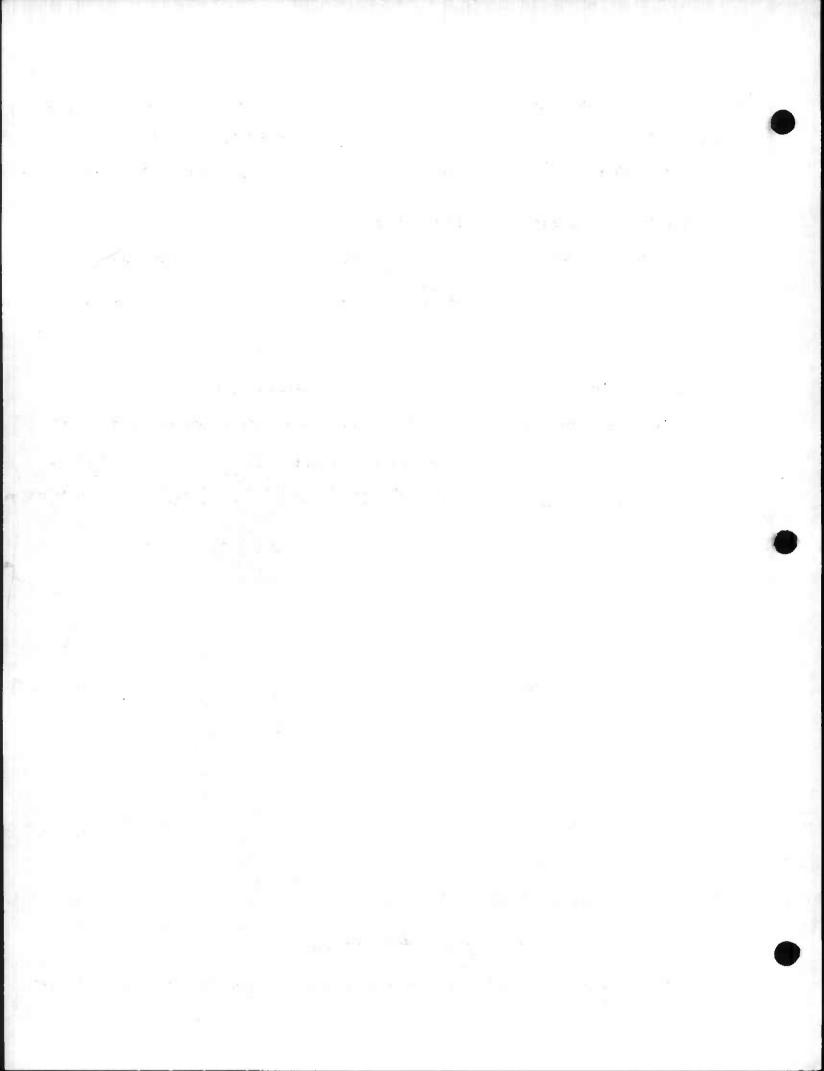
State of Maryland / Department of Health and Mental Hygiene 14851 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Vee -LENA APRIL 1997 /Medical 2:15 AM 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth Washington Adventist Hospital Takoma Park Montgomery 5. Sociel Security Number if Under 1 Year | if Under 24 Hrs. 7. Age (In yrs. lest birthdey) Birthpiece (State or Foreign Country) **Funeral** 1□M 2KF Hours 562-46-7175 71 Director Yrs Mexico Usual Residence of Decedent the Maryland 10e State r is marked other than "natural", or frams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes XXNo Director Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20904 9 Featherwood Court #41 Mexico 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Mexican Specify: Mexican white à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) pemit. Pages 1 and 2 should be filed wi Deperment of Health and Mental hygien. Important: If them 27 is marked other that any Injury or other traumetic event. Domestic worker Housekeeping 17. Fether's Nema (First, Middle, Last) 18. Mothar's Neme (First, Middle, Meiden Sumeme) Be Gabriel Pena' unobtainable 19e. Informant's Neme/Raiatlonship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9 Featherwood Ct. #41 Silver Spring, MD 20904 Gabriel Merrill/Son 20b. Plece of Disposition (Name of camatary, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State Metropolitian Crematory Apr 28,1997 Alexandria, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21-Signature of Funeral Service Licensee 22. Name end Address of Fecility Takoma Funeral Home, Inc. uboll 254 Carroll St. NW Washington, DC 20012 23a. Part1. Enter theydisease, or shock, or heart failure. List antions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximete Interval Between Onset end Deeth Physiclan Immedieta Causa (Finel diseese or condition resulting in daath) /Medical arrest Examiner Physician/Medical Examiner requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Ceusa (Diseese or Injury that Initieted evants resulting In deeth) Lest physician s the burle P.O. Box 68760, Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? Discar 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Ware autopsy findings aveileble prior to completion of cause of death? 24e. Wes an eutopsy performed? The hx 1□Yes 2 No 1 Yes 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medical axeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No ဥ 12 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physiwithin 24 hours after deeth.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Mengar of Deeth 28c. injury et Work? 28b. Time of 28d. Describe how Injury occurred Division 1 Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physician: To the best of my knowledga, daath occurred et the time, deta and pieca, end due to the causa(s) end menner es steted.
2 Medical Examinar: On tha basis of examination and/or invastigation, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) and manner steted. Medical 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Dete sigged (Month, Dey, Year) Bayhui NaINT 39372 30. Name and eddress of person who completed gausa of dagth (Itam 23a) (Type, Frint) suit 324 32. Registrer's Signeture State whia Davidson-Randoll 1997 ▶ Registrar DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

						(Certifica	ate of	Death		R	eg. No.	1	14825	-
			1. Decedant's Nama (First, Middle	, Last)							a of Daat	h	Vere	3. Tima of Death	1
Ų.	Physici /Medi		Oscar Ear	l Mann						Apr		7, 1997	Yaar 7	7:35 AM	
	Examir		4a. Facility Nama (If not institution	, giva street and number	er)				4b. City, Town			4c. County			
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7	Funerai Director		5. Social Sacurity Number 217-44-0639 Usual Rasidance of Dacedant	6. Sex 7. 1 ☑ M 2 ☐ F	Aga (In yrs. 89		nday) If Und Month	er 1 Yaa s Days		Min. (Mo	a of Birth orth, Day, . 19	Yaar) , 1908		iaca (Stata or Fore try) rida	ign
	show ad at	7	10e. Stete 10b. County				or Location						1	0d. Insida City Limi	
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020	d2 should be filed within 72 hours after death with the Maryland in and Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show trawmatic event, its Marical Exprese must be notified at	by Funeral	1 Navar Marriad 2 Marri 3 Widowed 4 Divorced	Armed Force	s? □NoWor	ld	If Yas, sp	ecify Cul	oan, Maxican, F	uerto Rican,	etc.)		k, Whita,	atc.	
ŏ	2 hou		15. Decedant	s Education		16a. [Decedant's Us	ual Occu	pation			16b. Kind of Business/Industry			
Maryland 21215-0020	i within 7 iene. r than "n	Completed	(Specify only highas Elemantery/Secondary (0-12)	t grade completed) College (1-4c	or 5+)		(Giva kind of w lifa. DO NOT ealty S	usa ratin		working	τ	J.S. Gov	vernn	ent	
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ja	Ald be Alenta rked ric ev	To B	James Arthur Ma	ann					Ellie	Hendr	ix				
a	and Men marke		19a. Informant's Name/Relationsh	nip (Type, Print)		19b.	Meiling Addre	ss (Stree	t end Number	r Rurel Routa	Number	City or Town,	Stata, Zip	Coda)	
	1 and 2 Health a am 27 is other tra		Frances T. Mani	n/Wife		21	.14 Sem	inar	y Road,	Silve	r Sp	ring, M	sary1	and 2091(0
Baltimore,			20a. Method of Disposition 1 Deurlai 2 Cramation	2	20b. P	laca of I	Disposition (A	ame of other pla	April	Date	007	20c. Location -			
Ĕ	Pages nent of I ant: If the ary or o		4 Denetion 5 ☐ Other (Sp		Mo	ntgo	merv C	rema	torium.	Inc.	997	Bethesd	la. M	aryland	
alt	permit. Pages Department of Important: If it any injury or any or or or or or or or or or or or or or		21. Signature of Facility Robert A. Pumphrey Funeral Home												
m	88188		Bethesda-Chevy Chase, Inc. 7557 Wisconsin Av Bethesda, Maryland 20814-3501 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximate interval Bath												
			23e. Part1. Enter the disease, or	complications that caus		h. Do no	ot antar tha m	oda of dy	Ing, such as ca	rdlac or raspir	atory arra	ast,	- 1	Approximate Interval Batween	
V	Physician		SHOOK, OF HEART ISHING. LIST	only one cause or aco	1 111162.									Onset end Deeth	
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	pa tis	lhe		b	BONE		Buno	J	MINA	smory			1	2-725	
_	end end I-tran	хап	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury thet initiated events resulting in death) Last Due to (or as a consequence of): CANCER OF PRESTATE Due to (or as a consequence of):												
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Hecords,	w requir	Completed t								24	a. Was a pertorn	n autopsy ned?	eve co	ere eutopsy findings allable prior to appletion of cause death?	s
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	Physician: The lar r this certificate hes aral director, page 2	To	examinar? 1 ☐ Yas 2 ☑ No	Hospitel: 1 🗆 Inpa	atient 2 🗆	ER/Outp	patient 3 I	OOA O	her: 4 🗆 Nursi	ng Home 5	Reside	nca 6 □Otha	ar (Specify	1)	
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SIO	Attending or death. ector: After by the fune	catl	2 ☐ Accidant Invastig 3 ☐ Sulcida 6 ☐ Could n	ation			М		Yas 2 No						
DIVISION OF		Certification:	4 Homicide datamii	28e. Pleca of building,	Injury - At ho etc. <i>(Spacif</i>)	oma, farr	n, streat, facto	ory, office		28f. Loc City	ation (St.	reet and Numbe , Stete)	er or Plura	l Route Number,	
	To the Hospital or within 24 hours eff To the Funeral Di completely filled in	edical	29a. Certiflar (Check only one) 1☑ Certifying 2 ☐ Medical E	Physician: To the back xaminer: On the basis and mannar	of axaminat	wledge, ion and/	daath occurre or Invastigation	d at tha t on, in my	ima, data and p opinion, daeth	laca, and dua occurred at the	to the ca e time, de	usa(s) and ma ete end piece, a	nnar as si and dua to	etad. the cause(s)	
	To the within 2 To the comple	Me	29b. Signetura end titla of certifiar	V				9c. Licen	se number		2	9d. Dete signed	(Month,	Day, Year)	
	6+1		1 Mich C	Actor	112	w	folia	D173	68			yho.	147		
			30. Nema and address of person w	no complated causa o	f deeth (Item	23a) (T									
			Stanley A. Sch					Park	Drive.	#210.	Sil	ver Spr	ing.	MD 20902	2
	Sta	ite	31. Data filed (Month, Day, Year)	32. Regi	Arar's Signa	ture	- Rando De						- 07		



BEATRICE CATHERINE MILLS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** Month
April 27, 1997

April 27, 1997

Ac County of Death Beatrice Catherine Mills /Medicai 3:14 AM 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death Examiner Doctor's Community Hospital Prince George's If Undar 1 Yaar If Undar 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth
(Month, Day, Year)
July 7, 1911 Birthplace (State or Foraign Country) **Funeral** 1□ M 2⊠ F 214-36-3303 85 Yrs. Director Tennessee Usual Rasidenca of Dacedant 72 hours after death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23e or 28a-f shor traumatic event, in a Modical Examinating the notified at Maryland Prince George's Cottage City 1 ☑ Yas 2 ☐ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20722 3731 Cottage Terrace U.S.A. by Funeral 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 ☐ Yas 2 ☒ No If Yas, Give Year or Datas: 1 □ Navar Married 2 □ Married 1 Yes 2 No Specify: Specify: White 3 ☑ Widowad 4 ☐ Divorcad Completed 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry 2 should be filed within and Mental Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Fathar'a Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Frank Marsico Mattie Ida Elizabeth Estep 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Theodore W. Mills, Jr. - Son 11294 Old Hopkins Road, Clarksville, MD 21029 27 20b. Placa of Disposition (Nama of camatery, cramatory or other placa) 20c. Location - City or Town, Stata to ortant: If i 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 5/1/97 Cedar Hill Cemetery 4 ☐ Donetlon 5 ☐ Othar (Specify) Suitland, Maryland 21. Signatura of Funaral Servica Licensee 22. Nama and Addrass of Facility Francis Gasch's Sons Funeral Home, P.A. della 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** heart failure /Medical Immediate Cause (Final disease or condition rasulting in death) Consestine mules Examiner Examiner physician and the burial-transit Sequantially list conditions, if any, laading to immediata causa. Enter Undarlying Causa (Disaesa or Injury thet Initiated events rasulting In daath) Last Coronary Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consaquance of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Chronic abrial of brillation signed by d 1 Yes 2 No 3 Probably 4 Unknown þ Chronie Obehuelino tang diseas, Old 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performad? Cerefro vascular osci cleut 1 Yas 20 No Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifica 25. Was casa rafarred to madical Be 26. Pleca of Daath (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Other (Specify) 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending 1 Yas 2 No invastigation 6 Could not be detarmined 3 Suicida 28f. Location (Straet and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowladga, daath occurred at the time, date end plece, end dua to the cause(s) and mannar as stated.

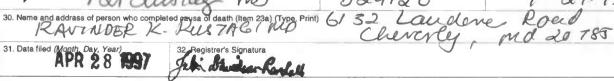
2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, date and plece, and dua to the cause(s) and menner stated. Medical

State

To the I within 2

31. Data filed (Month, Day, Year)

29b. Signatura and titla of certifiar



29c. Licanse number

024720

29d. Data signed (Month, Day, Year)

DHMH 16 Rev 6/95

Registrar

13 20 % p to the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Item:5 per informant G-752 10/2/97 dh 1. Decadent's Nama (Firşt, Middla, Last) 2. Date of Deeth 3. Time of Death MINKER **Physician** Year ELIZabeth 835 Apri 28, 199"-4c. County of Death /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Yaar If Undar 24 Hrs.

Months Deys Hours Min. Social Sacurity Number 212-18-9087 212-78-9087 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foraign Country) **Funeral** 1□ M 2⊠ F Deys Director 92 Yrs September 15, 1904 Maryland Usual Rasidance of Decedant Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryland sent of Health end Mental Hygiene.
Int. If Item 27 is marked other than "natural", or itams 23s or 28s-f show 10a State 10b. County 10c. City, Town or Location r than "natural", or itams 23s or 28s-f show the Medical Examiner must be notified at 10d. Insida City Limits Director 1 ☐ Yas 2 ☑ No Maryland Cecil Perryville 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? Completed by Funeral 1072 Principio Furnace Road 21903 United States 12. Was Decedant Evar In U.S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, White, atc 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☐ Married 21215-0020 1 ☐ Yes 2 ☒ No White Specify: 3 X Widowad 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) Bank Director Banking Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumame) Be Allen Crouch Amelia Pennington 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) Lily Amelia Lokey / Daughter 1072 Principio Furnace Road, Perryville, MD 21903 or othe 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Locetion - City or Town, State Data 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Department of Important: If any Injury or May 1 4 ☐ Donation 5 ☐ Other (Specify) Hart's Cemetery Elk Neck, Maryland 21. Signature of Funeral Service Ligenses 22. Nema and Addrass of Fecility Crouch Funeral Home 127 South Main Street, North East, MD 21901 23a. Pert 1. Entar the diseesa, or complications that caused tha death. Do not entar the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Physician /Medical immedieta Causa (Final diseasa or condition rasulting in death) Examiner Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disaasa or Injury that initieted evants rasulting in daath) Last pue the buriel-trar Division of Vital Records, P.O. Box 68760, physician Physician/Medical Dua to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? is certificate has been signed by director, page 2 should be detact 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Wara autopsy findings evellable prior to completion of causa of daath? 24a. Was an autopsy performed? certificate has 1 🗆 Yas 2 0 No 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Was case refarred to medical 26. Placa of Death (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 1 Yas 2 No 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Certification: 28b. Tima of 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Dascribe how Injury occurred After 5 Pending Investigation 1 Naturel To the Hospital or Attenditional within 24 hours after death.

To the Funeral Director: A completely filled in by the forms. deeth. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 3 Sulcida 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Spacify) 28f. Location (Straal and Number or Rural Route Number, City or Town, Stata) 4 Homicida 29a. Certifia 1 Cartifying Physician: To the bast of my knowledge, deeth occurred at the time, data and place, and due to the ceusa(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the fime, data and place, and due to the ceusa(s) end manner stated. Medical 29b. Signeture and title of certifier 29d. Dete signed (Month, Day, Year)

State

Registrar

12

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e of Maryland / Department of Health and Mental I	Hygiene	0.7	11.05
Certificate of Death	Reg. No.	21	1485

Physician
/Medical
Examiner

Margie 4a. Fecility Neme (If not institution, give street end number

4 4b. City, Town, or Location of Death

2. Dete of Death

Month

3. Time of Deeth Yeer 11:32 pm 97

5

Funeral

5. Social Security Number 577-20-6734 Usuel Residence of Deceden 10b. County

Sacred

Nursing Home 1□M 2K)F

7. Age (In yrs. lest birthday) If Under 1 Year If Undar 24 Hrs. Months Deys Hours Min.

Hyats ville, AD Prince Ce orges 8. Date of Birth (Month, Dey, Year) AUG. 18, 1 9. Birthpieca (Steta or Foreign 1904 NORTH CAROLINA

4c. County of Death

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

à

Completed

Be

the Maryland

With

permit. Peges 1 and 2 should be filled within 72 hours effer death a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23eans injury or other traumatic event, the accountance of the peace.

Physician /Medical

Examiner

ettending physician and for use es the burial-transit

certificate hes

To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifice

filled in by the

death certificate be

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

þ

Completed

Be

2

Certification:

Medicai

10a. Stata MD.

PRINCE GEORGES

10c. City, Town or Location HYATTSVILLE

10d. Inside City Limits 1 Ves 2 No

10e. Street end Number

5419 19th AVE.

1. Decedent's Neme (First, Middla, Last)

10f. Zlp Code 20782 10g. Citizen of Whet Country?

11 Meritel Status 1 Navar Married 2 Married

12. Was Decedent Ever In U,S. Armed Forceş? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:

 Wes Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 1 Yes 2 No Specify:

UNITED STATES AMERICA
14. Race - American Indien,
Bleck, Whita, atc. Specify: BLACK

3 XWidowed 4 ☐ Divorced

15. Decedent's Education (Specify only highast grade completed)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elamantary/Secondery (0-12)

College (1-4or 5+)

(DAUGHTER)

DOMESTIC

PRIVATE

5th GRADE 17. Fether's Name (First, Middle, Last)

MARIAH HILL

18. Mother's Name (First, Middle, Meldan Surname)

20782

ALFRED DAVIS

19e. tnforment's Neme/Reletionship (Type, Print)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

ELMA V. MARSHALL

20e. Method of Disposition 1 Buriai 2 ☐ Cremetion 3 ☐ Ramovel from Stete

5419 19th AVE. 20b. Ptece of Disposition (Neme of cematery, cremetory or other plece) HYATTSVILLE, MD. 20c. Location - City or Town, Stata 4/29/97

4 ☐ Donetion 5 ☐ Other (Specify)

LINCOLN MEMORIAL CEMETERY 22. Nama and Address of Facility

SUITLAND. MD.

21. Signature of Funeral Service Licensee

23a. Perf1. Enter the disease, or confplications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer feilura. List only one causa on each lina.

JOHNSON & JENKINS INC. 716 KENNEDY ST. N.W. W.D.C.

Approximate interval Between Onset and Deeth

Immediate Cause (Finel disaese or condition resulting in deeth)

Cardiopulmonas

Due to (or es a consequence of):

Sequentially list conditions, if eny, leading to immediata causa. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last

Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert i.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a, Was an autopsy

24b. Wara autopsy findings available prior to completion of cause of death?

1 Yas 2 No 26. Place of Deeth (Check only one)

1 ☐ Yes 280 No

25. Was case rafarred to medical exeminer? 1 Yes 200No

5 Pending Investigation

6 Could not be determined

28a. Dete of injury (Month, Dey Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: Nursing Homa 5 Rasidence 8 Other (Specify) 28c, tnjury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

(Check only

27. Menner of Death

1 ☑Neturei 2 ☐ Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signatura and titla of certifiar

29c. Licansa number

29d. Dete signed (Month, Dey, Year)

D37934

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

Stanhania Trificalions 7500 breamers Center Dane Greenhalt AD 20770

31. Dete filed (Month, Day, Year) State Registrar

APR 29 1997



DHMH 16 Rev 6/95

4/25/97

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

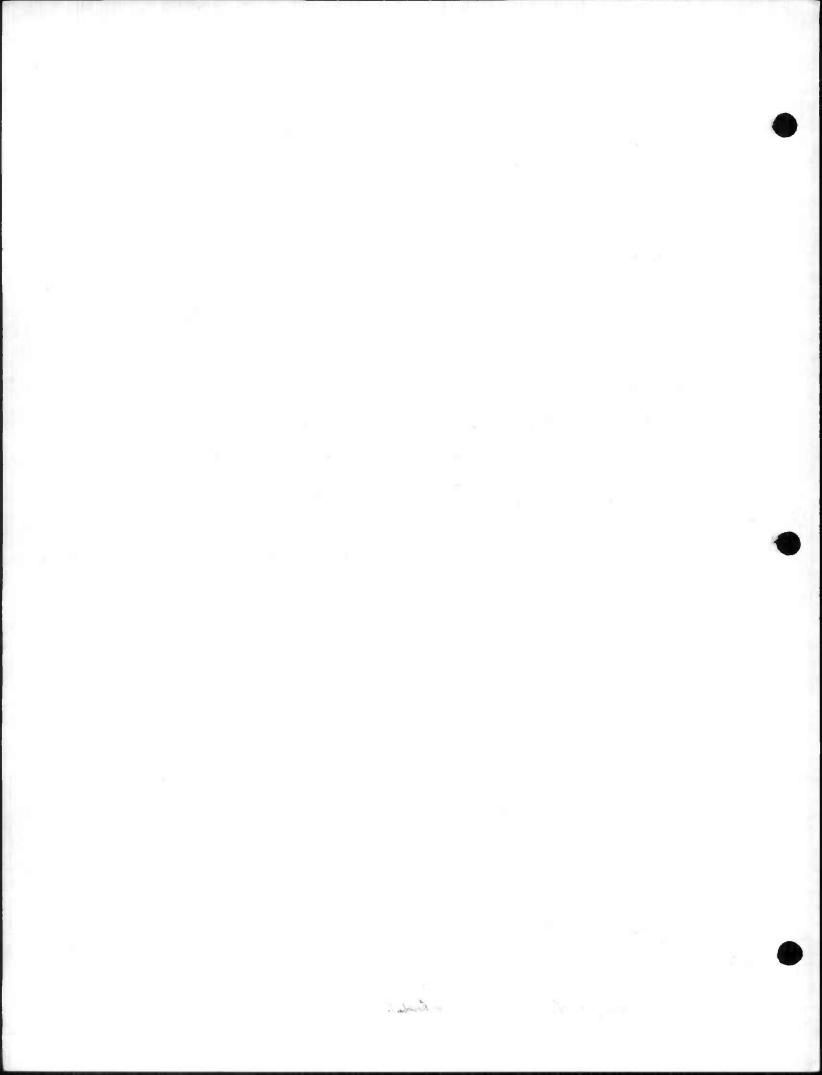
age of the same has been

State of Maryland / Department of Health and Mental Hygiene 9 7

14856

						Ce	rtificate o	t Death		Reg. No.		
	Physic /Medi		1. Decedent's Name (First, Middle, La RAZIA MALI	K					2. Date of D Month 4 –	Day 27-97	Yeer	3. Time of Death 5:00pm
7	Exami		4e. Facility Neme (If not institution, gin HOLY CROSS HOSPI		nber)			4b. City, Town, or SILVER S	PRINGS	MONTO	y of Deeth	
	Funeral Director		227-04-5634	Sax 1□M 2XF	7. Age (In yrs. 59	last birthday) Yrs.	If Undar 1 Yas Months Dey			irth <i>Jay, Year)</i> 38	9. Birthp Coun Pak 1	eleca (State or Foreigr etry) Stan
	with the Maryland a or 28a-f show be notified at	ctor	Usual Residence of Decedent 10e. State 10b. County Maryland Montgom	nery		ty. Town or Lo					1	0d. Insida City Limits
	th with th	Funeral Director	3919 Lantern Dr.				10f. Zip Code 209			10g. Citizen of Usa	What Cour	itry?
020	72 hours after death with the Maryland "natural", or items 23s or 28s-f show ad cal Examinet must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Wes Deced Armed For 1 Tas if Yes, Give Year or Da	ces? 2 💢 No		Was Decedant of If Yes, specify Control of Italy Yes 2 ₺ N	f Hispenic Origin? (Suben, Mexican, Puer to Specify:	Specify Yas or N to Rican, etc.)	o- 14. Ra Ble Specia	ce - Americ eck, White, fy: As i	etc.
21215-0020	C 4 M	Completed	15. Decedent's E (Specify only highest gr. Elementery/Secondary (0-12)	ducation ada completed) College (1-	4or 5+)	16e. Deced (Give life.		cupetion na during most of wo ired) SEWIFE	rking	16b. Kind of B	lustry	
Maryland	S should be filed within and Mental Hyglena. S marked other than aumatic event, or Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Men	To Be C	17. Fether's Neme (First, Middle, Last Muhammed Jahagi					18. Mother's Na		e, Maiden Sumai	ma)	
lan	2 sho and is me		19a. Informent's Neme/Reletionship (,, ,				et and Number or R			, State, Zip	Code)
	1 and Health em 27		Muhammad Latif Ma	lik/ Hus				Dr,Silve	r Sprin		20902	
altimore,	Page nent o int: If		20a. Method of Disposition 1 □XBurlel 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Specif		tato	orge Wa	sition (Name of matory or other p IShingto	n		Adelph	i,Md.	
Bal	permit. Pag Department Important: I any Injury o		21. Signature of Funerel Service Licer	nsee M	ale	- 22		ress of Fecility Un nedy St,N				
	Physician		23a. Pert . Enter the diseese, or com shock, or heert feilure. List only	plications thet ca one ceuse on ea	used the deet ch line.	h. Do not ent	er the mode of d	ying, such as cardie	c or raspiratory	errest,	+	Approximete intervel Between Onset end Death
	/Medical Examiner	J.	Immediate Ceuse (Finel disease or condition resulting in deeth)	e. SUB		4NOID		MORRHAG	6			18 hours.
	and Il-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Couse (Disease or Injury	b	Due to (o	or es e conseq	uence of):					
ox 68760,	certificata be axecuted inding physician and use as the burial-transit	/Medical E	Cause. Entar Underlying Ceuse (Disease or injury thet initieted events resulting in daath) Last Due to (or es e consequence of):									
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Records,	requiras been sign should be	Completed by								s en autopsy formed?	cor	ere autopsy findings eileble prior to mpletion of cause deeth?
E.	0 - 0	NO.							1 🗆	Yes 20 No	10	Yes 2□ No
/ita	delan: The	Be	25. Wes case referred to medical examiner?						ath (Check only	one)		
on of Vital	ding Phys h. After this funeral di	tion: To	1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pending 2 Accident Investigation	28e. Date of (Month		ER/Outpetier 28b. Time of Injury	28c. In			how injury occu)
Division	al or Attanding s after death. I Director: After d in by the fune	Certification:	3 Suicida 6 Could not b	a 28e. Piece o	of Injury - At ho g, etc. (Specif	ome, ferm, str y)	eet, fectory, offic	e		(Street and Num. own, State)	ber or Rura	l Roufa Number,
	To the Hospital within 24 hours a To the Funeral C	edicai C	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the bas and menne	als of exemine	wledge, deeth tion end/or inv	n occurred et the vestigetion, in my	time, dete end plece y opinion, deeth occu	e, end due to the urred at the time	ceuse(s) end m , date end plece,	anner as st end due to	eted. the cause(s)
1	To the To the comple	Me	29b. Signature and title of certifier	bourt	En	MA	1	nse number		29d. Date signed APRIL		
				completed cause		1 23e) (Type,	Print)	26540 rederick	Nd.	Gait	Lewb	ung

State Registrar



21215-0020

Box 68760,

Division of Vital Records, P.O.

31. Data filad (Month, Day, Year) State Registrar

29b. Signature end title of certifiar

MB 11701 LIVING Ston Rd, FORT WASH, Md 207424

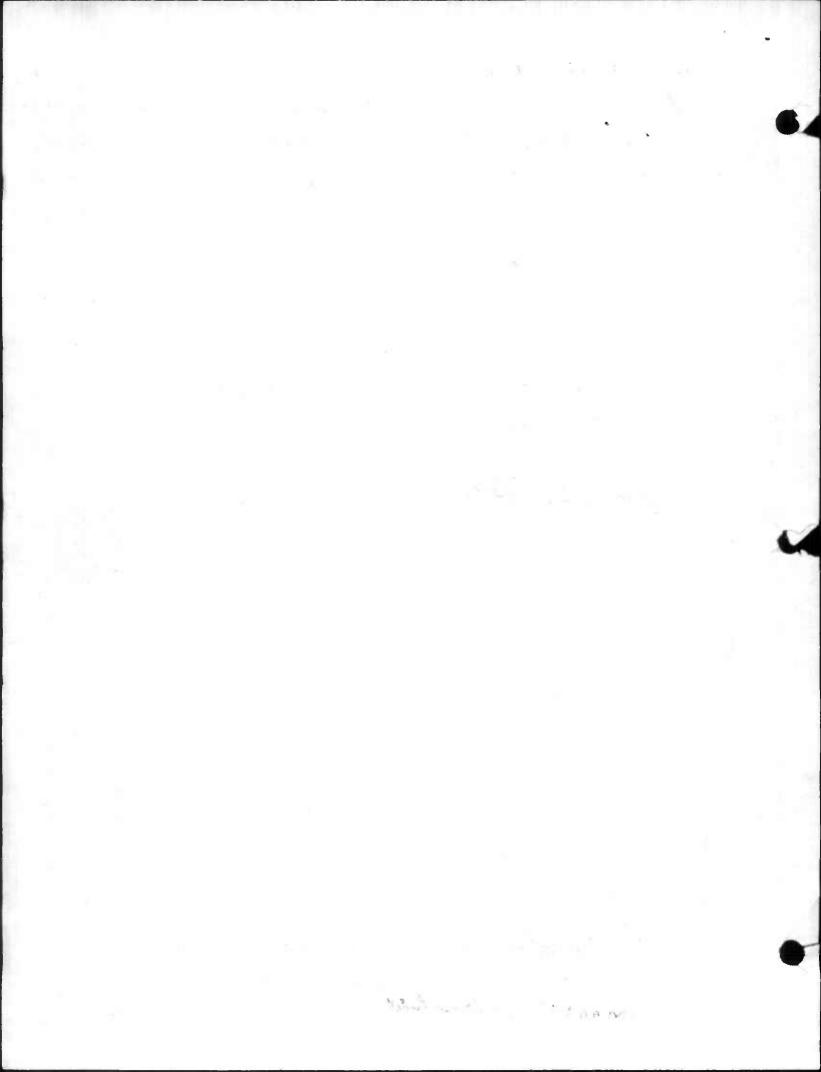
30. Nama and addrass of person who complated ceusa of death (itam 23a) (Type, Print)

NEGZBALR

29c. Licensa numbar

007348

29d. Date signed (Month, Dey, Year)



1	-	STATE REGISTR	AR
II.	_	COCOCNITIO	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

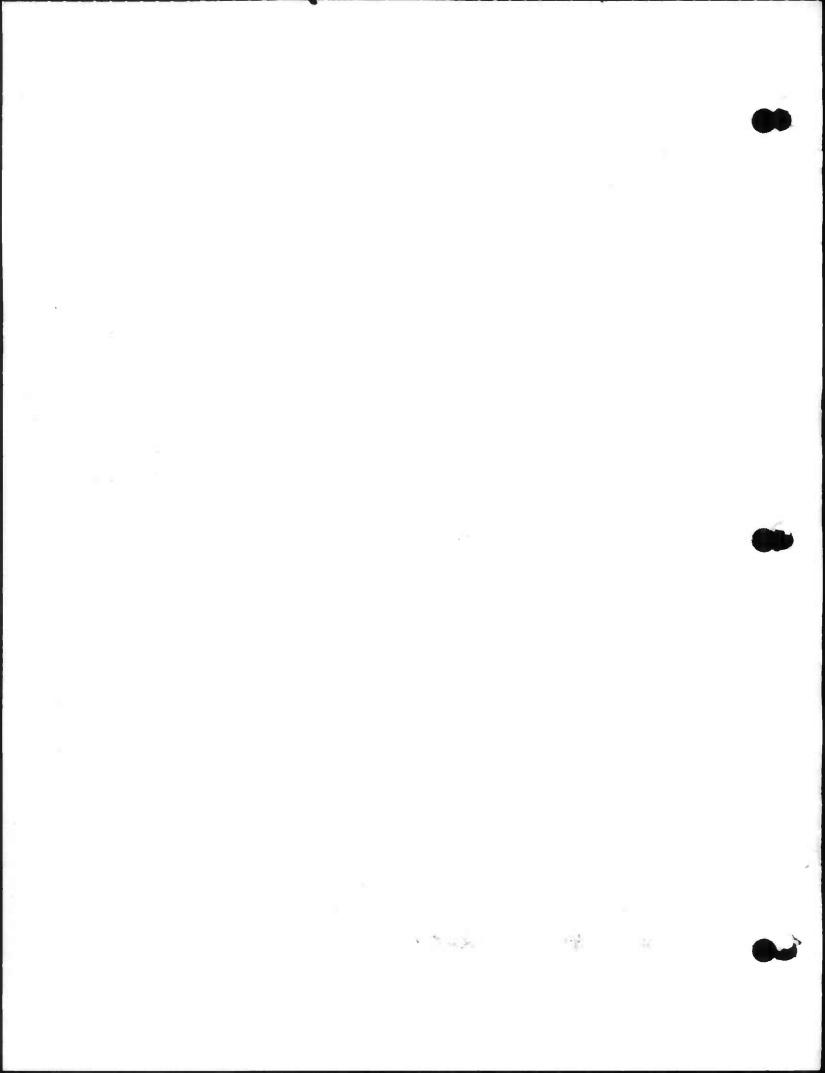
	REGISTRAR	C	ERTIF	ICATI	E OF	DEATH	REG. NO) .				
	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH											
DIRECTOR	Grover Adelbert Moore						April 3	30, 19	995	8:10 am м		
	4. SOCIAL SECURITY NUMBER 5. SEX	6, AGE (In yrs. la	st birthday)	IF UNDER	R 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH			IPLACE (State or Foreign		
	577-40-1507 1 😾 M 2 🗆 F	71	YRS.	MONTHS	DAYS	HOURS MIN.	Oct 12,	1925	Ma	ryland		
	9a. FACILITY NAME (If not institution, give street and number)			9b. CITY	r, TOWN C	OR LOCATION OF DE		9c, COU	JNTY OF D	-		
	Larkin Chase Nursing Cer								George's			
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY											
	Maryland Prince Georg	1010				ION		10d. INSIDE CITY LIMITS?				
	10e. STREET AND NUMBER	Riverdale 100, ZIP CODE					10a CI7	TITEN OF I	1 🔀 YES 2 🗌 NO OF WHAT COUNTRY?			
FUNERAL	6311 59th Avenue	20737						·S·A				
ВУ	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECED FORCES? IF YES, GIVI	ENT EVER IN U.S. A	. ARMED 13. WAS DECENDENT OF HISPANIC If yes, specify Cuban, Maxican, 1 ☐ YES 2 ☑ NO Specify:				n, Puerlo Ricen, etc.)	E — American Indian, k, White, atc. White				
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16e. Di	ECEOENT'S	USUAL O	CCUPATIO	ON .	16b. KIND OF BI	JSINESS/IN	OUSTRY			
COMPLETED	Elementery/Secondary (0-12) College (1-4 or	lih.	(Give kind of work do life. Do NOT use retire			st of working						
	12	H	ome I	mpro	veme	nt	Const					
00	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Maide					
TO BE	Berry Eugene Moore		Vida Merle Sandborn									
	19a. INFORMANT'S NAME (Type/Print)	19	b. MAILING	AOORES	S (Street a	nd Number or Rural I	Route Number, City or To	wn, State, Zi	p Code)	1 1 20700		
	Donna Walker-Ottey		9045	Con	tee	Road apt	301, Lau	rel,	mary	1and 20708		
	20a. METHOD OF OISPOSITION 1 Striel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Maryland Veteran's Cemetery 1997 Cheltenha								city or To	wn, State Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Claudette d. Dascl Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 207											
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heert fellure. List only one cause on each line. Approximate interval Between Charles (Flori) Approxim											
	disease or condition resulting in death) a. TERMINAL CARCINOMA OF JUNG. >3-Month DUE TO (OR AS A CONSEQUENCE OF): STAGE TO											
	Sequentially liet conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):											
												PART II. Other eignificant conditions contributing
MEDICAL	Dysphagia;	a ;	C	AD; H	PERFORMEO? 1 — YES 2 NO			AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?				
	DID TOBACCO USE CONTRIBUTE TO C	AUSE OF DEA	ATH YE	S 🔲 I	NO [UNCERTAIN	V 🔯	'				
N S	25. WAS CASE REFERRED TO MEDICAL		CE OF DEA	TH (Check	only one)							
PHYSICIAN:	HOSPITAL	☐ ER/Outpetlent 3	DOA	OTHEI 4 XINUT		5 Realdenca	6 Other (Specify)					
	1 20 Natural 5 Pending	Day, Year)	26b. TIM	7	28c, INJI WO	JRY AT RK?	28d. DESCRIBE HOW	INJURY OC	CURED			
BY	Accident Investigation 3 Suicide 6 Could not be 28a. PLACE	OF INJURY — At be	M 1 YES 2 NO At home, ferm, etreet, factory, office				201 0017101 01					
TED	4 Homicide determined building	g, etc. (Specify)	noma, term, etreet, tectory, office				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLETED	29a. CERTIFIER (Check only one) 2/ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	Doa				29c LICENSE NUN	IBER 4525	29d. DAT	E SIGNED	(Month, Day, Year)		
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27 CIPDO, PINITUDE ROOD; #220; BOWNO-MD-20716											
	31. OATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE											

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should by filled within 72 hours after death with the State Dept. of Health and Mental Hypiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

OHMH-18 Rev 1/89



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death Month . **Physician** 4b. City, Town, or Location or Death 8:25pc CONTE OLIVE 30 /Medical 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Undar 1 Yaar If Undar 24 Hrs. Months Deys Hours Min. 5 Social Security Number 8. Date of Birth (Month, Dey, Year) SEPT. 5, 7. Age (in yrs. last birthdey) **Funeral** 9. Birthplece (Steta or Foreign Deys 10 M 2XX 58 1938 SIERRA LEONEAN 219-11-1223 Yrs. Director Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be nothled at MARYLAND PRINCE GEORGES HYATTSVILLE WYes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? UNITED STATES ò 1903 AMHERST RD. APT. #203 20783 permit. Pages 1 and 2 should be filed within 72 hours after death v Deperment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a eny Injury or other traumatic event, the Medical Examiner mass and 00.06. items 23s Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 22 DNo NO If Yes, Give Year or Detes: 13. Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Bleck, White, atc. 1 Never Merried Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ (No Specify. BLACK þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadent's Education Decedent's Usuel Occupetion
 (Give kind of work done during most of working life. DONOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) Elemantary/Secondery (0-12) College (1-4or 5+) MEDICAL 12TH 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surneme) Be JOHNNIE RENNER-DUPIGNY MANONA RENNER Lo b. Mailing Address (Street and Number of Rural Routa Number, City or Town, State, Zip Code)
1111 KINGS TREE DRIVE
MITCHELLVILLE, MARYLAND 20721 19e. Informent's Neme/Reletionship (Type, Print) DAPHNE M. OLADIMEJI/DAUGHTER 20a. Method of Disposition
AD Burial 2 Cremation 3 Removal from State 20b. Plece of Disposition (Name of cametary, cremetory or other plece)
MARYLAND NATIONAL CEM. Dete 20c. Location - City or Town, State MAY 10, 1997 LAUREL, MARYLAND 4 Donetlon 5 Other (Specify) 21. Signatury of Fynerel Service Ucense 22. Name and Address of Facility DUDLEY FUNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, MD EDWARD M. DUDLEY 20712 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or heart feilure. List only one causa on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Eden diseese or condition resulting in deeth) Examiner Due to (or es e consequença of) The law requires that the death certificate be executed Sequentielly list conditions, if eny, laeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Due to (or es e consequença of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical Due to (or as a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detec 1 Tyes 2 2kNo 3 Probably 4 Unknown à Be Completed 24b. Were autopsy findings evellable prior to completion of cause of deeth? 24e. Wes en eutopsy performad? ate has 20 No certificate 1 Yes 2 No I or Attending Physician: after death. 25. Was case referred to medical 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 2 1 Nes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending invastigation Neturel 1 Yes 2 No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Plece of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 4 Homicide Hospital of the Pours a Funeral Medicai 29e. Certifier To the Hosp within 24 hou To the Fune completely fi 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner es stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) end menner stated. 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) apr. 130 199 D08546 Som washos 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 8218 W & GUSIN bhwi Da 32 Registrar's Signeture 31. Dete filed (Month, Dey, Year) State

DHMH 16 Rev 6/95

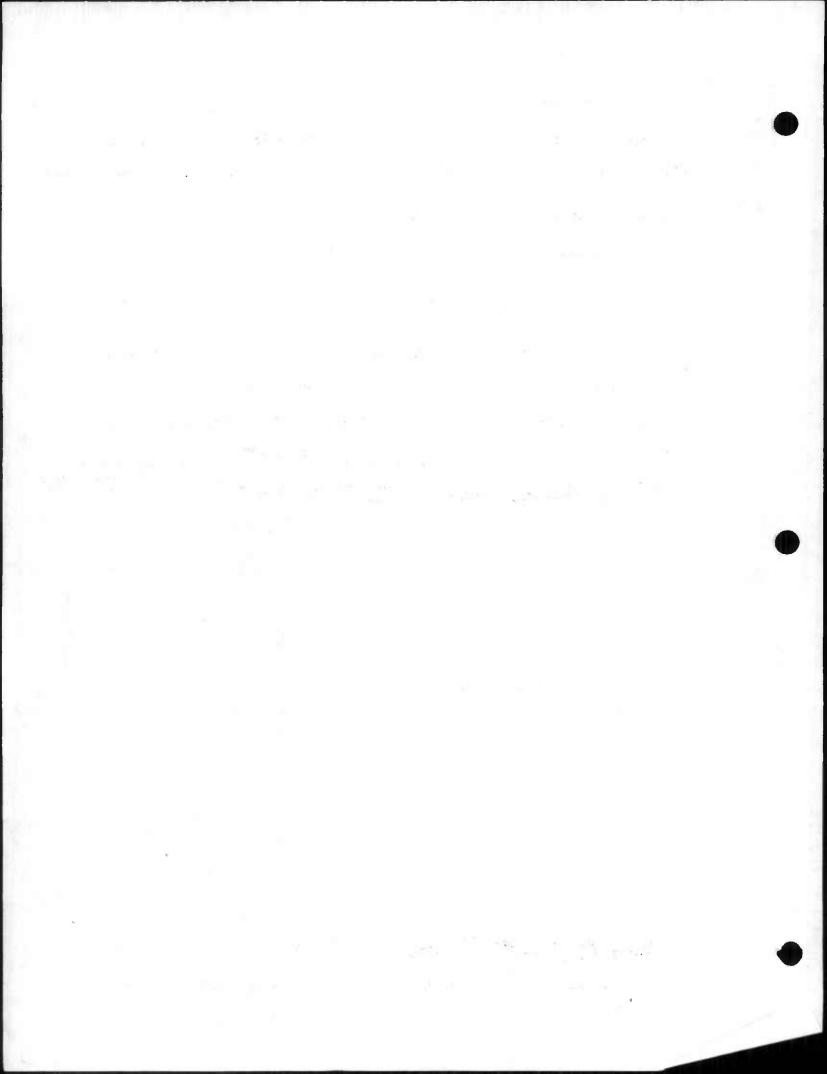
Registrar

01

Section 1

State of Maryland / Department of Health and Mental Hygiene 97 14860

				Certificate of	of Death			Reg. No.				
sician	1. Decedent's Name (First, Middla			2. Date of Do	eath	_Year	3. Tima of Deeth					
edical	Roger b	1		April 30, 1997		97	5:45 P.M					
miner	4a. Facility Name (If not Institution,			cation of Dea		of Death						
		7912 Robison Road				iesda		Montgomery				
rai lor	5. Social Sacurity Number 218-38-5483	6. Sex 7. A 1⊠M 2□F	Age (In yrs. lest bir 83	thday) If Under 1 Ye Yrs. Months Da		Min	8. Date of Bi (Month, D Dec . I	rth ey, Year) 1913	9. Birthp	place (State or Foreign ptry) h Dakota		
	Usual Residence of Decedent						Jec. I	, 1913	South	n Dakota		
	10a. Stete 10b. County	n or Location					1	10d. Inside City Limits				
ctor	Maryland Mont	1 ☐ Yes 2 ☒ N										
Director	10e. Street end Number	10f. Zip Cod	е			10g. Citizen of What Country?						
								United States				
Funerai	11. Maritel Status	12. Wes Decader Armed Forces	nt Ever in U,S.	13. Was Decedent	of Hispanic Or Juben, Mexican	lgin? (Spec	cify Yes or Ne	0- 14. Ra	ca - Americ			
by F	1 ☐ Nevar Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorcad Year or Dates: WW T.T.			1□ Yes 2⊠!			Specify: White					
Pa Pa	16 December 15 December 15	Year or Dates	1 22	Decedent's Heart Oc	N				· wn:			
Completed	15. Decedant' (Specify only highest	grede completed)		Decedent's Usual Oc (Give kind of work do life. DO NOT usa re	ne durina mos	st of workin	9	16b. Kind of B	Business/Ind	dustry		
E O	Elementary/Secondary (0-12)	Collega (1-4o		conomist				U.S. Go	overni	ment		
BeC	17. Fether's Name (First, Middle, Last)				18. Mother's Neme (First, Mid							
ToB	Roy Bert Nelson			Mary Ste								
-	19a. Informant's Name/Relationsh	p (Type, Print)	19b	Malling Address (Str	eet end Numbe	er or Rural	Route Numb	er, City or Town	, Stete, Zip	Code)		
	Myrtle G. Nelso	n/Wife	79	12 Robison	n Road,	Beth	nesda,	Marylan	nd 20	0817		
	20a. Method of Disposition 1 Burial 2 □ Cremation	Removal from State	20b. Placa of cameter	Disposition (Nema of y, cremetory or other)	pleca)	2 110	Date	20c. Location	- City or To	own, State		
	4 □ Donation 5 □ Other (Spi		Glenwo	ood Cemete	ry May	3,19	97	West Lo	ng Br	anch, NJ		
	21. Signature of Funeral Service L	censee		22. Name and Ad Robert A	dress of Facility	ty rev I	Tunera	1 Home/	Bethes	sda-Chevy		
	22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Chase, Inc. 755/ Wisconsin Avenue Bethesda, Maryland 20814-3501											
	23a. Part1. Entar the disaase, or of shock, or hear failure. List of	omplications that cause nly ona cause on each	ed the deeth. Do r				respiretory a	irrest,		Approximate Interval Between		
ı.									1	Onsat and Death		
	immediata Causa (Final diseasa or condition resulting in death)	aAthero	scleroti	c Cardiova	scular	Dise	ease			10 Years		
ē			Dua to (or as a o	consaquance of):								
Examiner		b	Due to fee a	3								
	Sequentially list conditions, if any, laading to immediate cause. Filer Underlying											
Medical	cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death), fact	C	Due to (or as e c	onsequanca of):								
Med	resulting in death) Last Due to (or as e consequence of):											
		d										
Physicial	Part II. Other significant condition	contributing to death	but not resulting in	the underlying cause	given In Part I		23b. Dld	tobacco use co	ontribute to	the cause of death?		
	Congestive Hea	rt Failure				1 ☐ Yes 2 ☒ No 3 ☐ Probably 4						
d by	Songestive heart railure											
Completed	Hypertension						24a. Was	en eutopsy ormed?	eve	ere autopsy findings eilable prior to mpletion of cause		
J D									of c	mpletion of cause death?		
							10	Yes 2, No	1[Yes 2□ No		
o Be	25. Wes casa referred to medical axaminer?	Hospital:			Whor:		(Check only					
-	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 lnpat		patient 3L DUA	4 □ Nu			danca 8 Oth		0		
ertification:	1 Natural 5 Panding (Month, Day Year) Injury Work? 2 Accident invastigation 3 Suicide 6 Could not be determined determined.						28f. Location (Street and Number or Rural Route Number,					
Hice												
Cert	4 LI TIGHICIDE	building, e	fc. (Specify)	·			City or To	wn, Stafa)				
fedical	one)	end manner s	teted.	or investigation, in m	y opinion, daat	in occurred	at the time,	date end place,	and due to	tne cause(s)		
Σ	29b. Signature end title of certifier 29c. Licen					nse number			29d. Dete signed (Month, Day, Year)			
	Jan My	/ Cunt	7 m		D15928			May 1,	1997	7		
	30. Name and address of person with	o complated cause of	death (Itam 23a) (Type, Print)								
	Gary M. Koritzi			Street, N.	W. #40	1, Wa	shing	ton, DC	20037	7-1899		
State strar	ļ , , , , , , , , , , , , , , , , , , ,	asky, M.D.,		Street, N.	W. #40	1, Wa	shing	ton, DC	20037	7-189		



State of Maryland / Department of Health and Mental Hygiene

11.061

					Certi	ficate	of Death		Reg. No.		4001			
Physic	ian	1. Decedent's Name (First, Middle					100	2. Date of I Month		Year 3.	Time of Death			
Med/	ical	NORA J. O'BOYL		455.4					20, 199		:50am			
Exami	ner	4a. Facility Name (If not institution,						n, or Location of De	eth 4c. Count	y of Death				
	,	Brooke Grove Re 5. Social Security Number	habilitat 6. Sex	7. Age (In yrs.		Ctr.		Spring		gomery	10.00			
Funeral Director		013-50-3012	1□ M 2∑F	103		Months D		Min. (Month,	Day, Year)	9. Birthplace Country) Irela	(State or Foreig			
and w		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Local	ion				10d le	nside City Limits			
the Marylan 28a-f show	ctor	Md. Montg	omery		kville						Yes 2 No			
th with th	Funeral Director	10e. Street end Number 7117 Panorama D	rive			10f. Zip Co	ode 0855		10g. Citizen of United	What Country?				
death	Jera	11. Maritei Status	12. Was Dece	edent Ever in U.	S. 13. We			n? (Specify Yes or I		ce - American In	dian.			
5-0020 72 hours effer death with the Maryland nature!', or Hems 23a or 28a-1 show and I an and I and a show a least the motified as	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorcad	Armed Fo	rces? 2 No e	HY	es, specify Yes 2X	Cuban, Mexican, I	Puèrto Rican, etc.)	Bie	ck, White, etc. by: White				
T. s 1.8	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grede completed) College (1	-4or 5+)		d of work o NOT use r	lone during most o etired)	f working	16b. Kind of B	lusiness/Industry	,			
of filed with all Hygiene.	S	12			Hou	sewif			Own I					
aryland should be filed and Mental Hygin merked other urratic event,	To Be	17. Father's Name (First, Middle, L Patrick Barry	a st)					Shannon Shannon	lle, <i>M</i> aiden Sumer	ne)				
Maryla Id 2 should Ith end Men 77 is merke		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailing	Address (S	treet and Number	or Rural Route Num	nber, City or Town	, State, Zip Code	в)			
		Michael J. O'B	Michael J. O'Boyle (son) 7117 Panorama Drive Rockville, Md 20855											
of He standard		20e. Method of Disposition		20b. P	lace of Dispositi	on (Name	of	Date		- City or Town, S	State			
Page Hent Int: If		1 ☐ Buriel 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.	3 ∐Removal from : ecify)	State			ematory	April 22	Alexano	iria, Va.				
Baltimore, permit. Pages 1 er Department of Hea Important: If Item 2 any Injury or other		21. Signature of Funeral Servica L	D St.	lons	10	E. De		Dr. Gaith		Md.2087	The state of the s			
Physician /Medical Examiner		23a. Part. Enter the disease, or of shock to hour failure. List of limited the control of the co	2	MON			dying, such as ca	indiac of respiratory	arrest,	Ons	roximate rval Between et and Death			
nted ansit	Examiner		b											
68760, tificete be executed g physician and es the buriel-transit	ai Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	C.	Due to (or	as a conseque	nce of):								
. Box 68760, death certificate be execut electricities by execut of for use es the buriel-transition of for use es the buriel-transition.	Medical	that initiated events resulting in death) Last		Due to (or	as a consequer	nca of):								
Box (death certif	ician/	Part II. Other significant condition	d.	ath hut not root	Mine in the conde	dulan anua	a shore in Boat I	not Di	d tobacco uas co					
O, the	hys		e continuenting to do				e giveri iii ratti,		Yes 2 No		42Unknow			
S, P	y P	CACHEXIA	AND	DEHY	BRATIO	N		_	108 2010	3 L Frobably	4)EL OHKHON			
Records, P.O. Bit is law requires that the death is hes been signed by the etterge 2 should be detected for	Completed by Physician/							24a. Wa	as an autopsy formed?	aveilable	utopsy findings e prior to ion of cause ?			
The land	0							1	Yes 2 No	1 ☐ Yes	2 □ No			
	Be (25. Wes case referred to medical examiner?					26. Place of	Death (Check only	one)					
- S 00 0	70	1 Yes 2 No	Hospital:	npatient 2	ER/Outpatient	3□ DOA	Other: 4 Nursi	ng Home 5 ☐ Re	sidence 6 □Ott	ner (Specify)				
Vision of Attending Proceedor: After the by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga		of Injury h, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describ	e how injury occur					
- P#9-	Certification:	3 Suicide 6 Could no determin	ed 28e. Place	of Injury - At ho ng, etc. (Specify	me, farm, street,	factory, of	fica		(Street and Numi own, State)	ber or Rural Rou	te Number,			
To the Hospital within 24 hours or To the Funeral Completely filled	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the taminer: On the ba	sis of examinat	viedge, death oc ion and/or invest	curred at thigation, in a	ne time, date end p my opinion, death	place, and due to the	e cause(s) and m e, date and place,	anner as stated. end due to the o	æuse(s)			
within 2 To the	M	29b. Signeture and title of certifier				29c. Ll	cense number		29d. Date signe	d (Month, Day,	Year)			

D33700

SANDY SPRINGI,

TED E. HOWE M.D. 20860

State Registrar 18100

we. mo

SLADE

31. Date filed (Month, Day, Year)

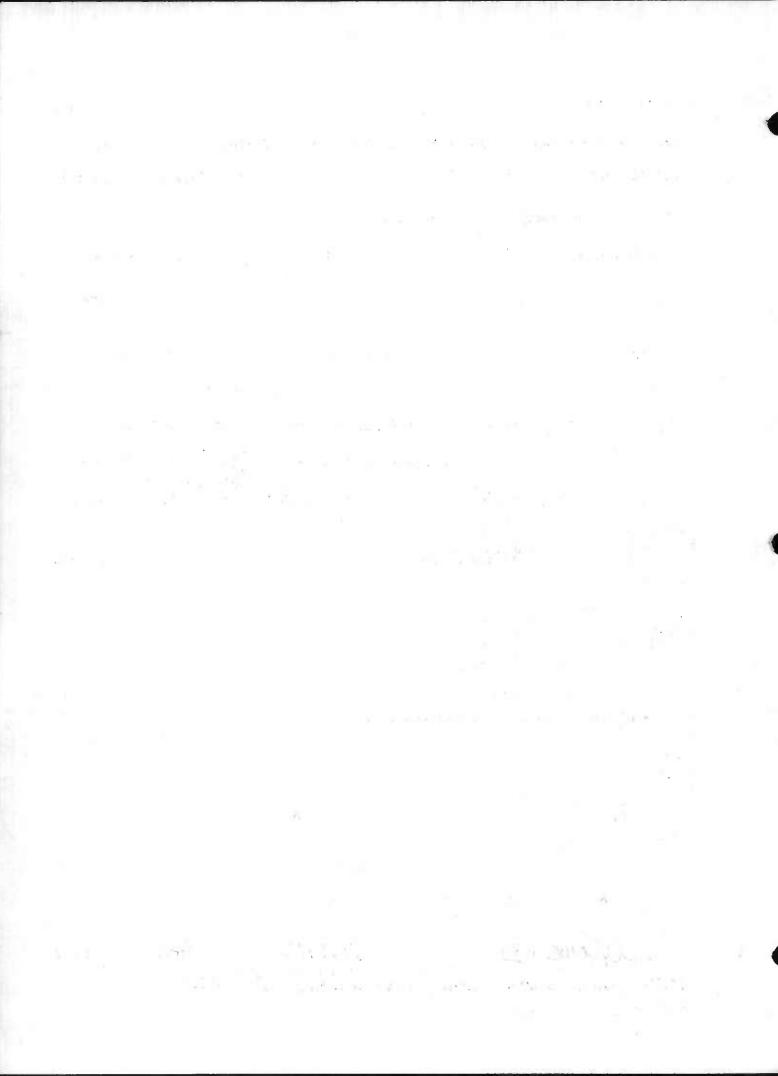
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

SCHOOL

APR 28 1997

2. Registracis Signature

White Davidson

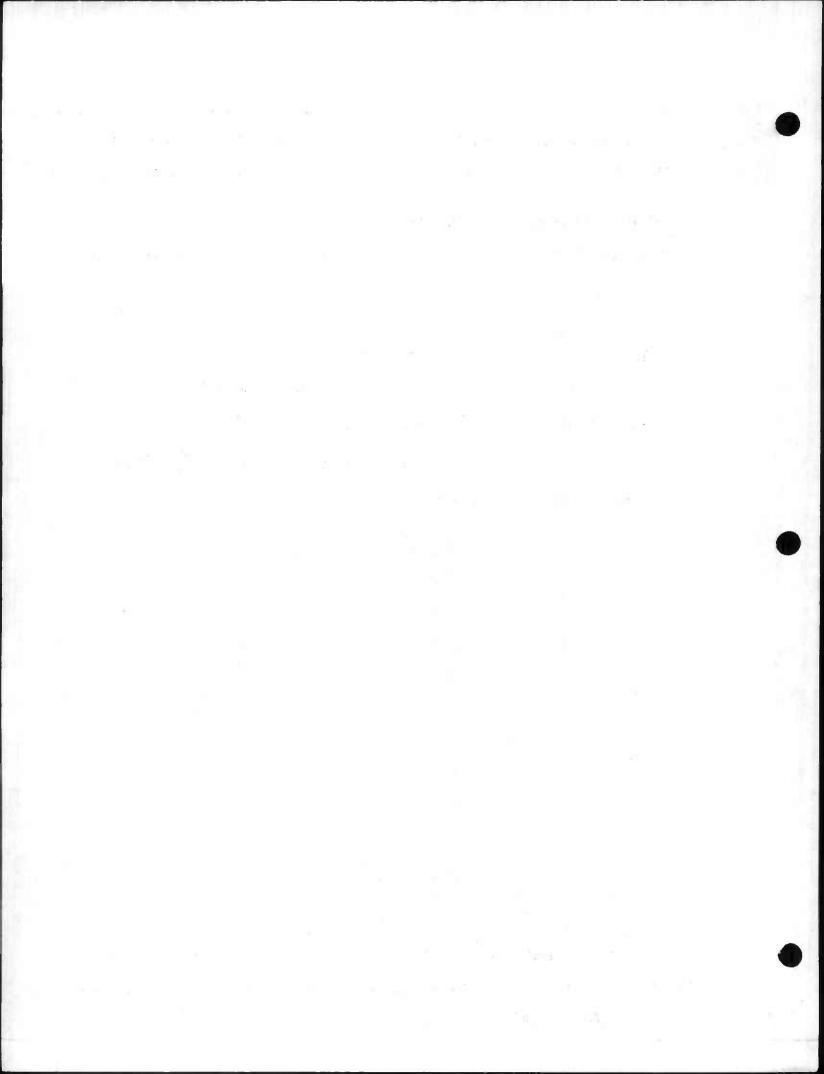


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

14862

		Certificate o	Dealli	F	Reg. No.			
Physiclan /Medical	HICE	OCCHIP		2. Date of Dea Month	28 /	Year 3. Time of Deeth 997 5.46		
Examiner	4a. Facility Name (If not institution, give street end number) Washington Adventist Hospita	1	4b. City, Town, or L Takoma P		To County	of Deeth comery		
Funeral Director	5. Social Security Number 169-24-3146 Usuai Residence of Deceden			8. Dele of Birth (Month, Day Oct. 30	y, Year)	9. Birthplace (Stete or Foreign Country) Pennsylvania		
Maryland Fed #1		ty, Town or Location				10d. Inside City Limits		
vith the Many to or 28e-f sh be notified.	Pennsylvania Lackawanna Dun	nmore				1 Yes 2 □ No		
	138 Willow Street	10f. Zip Code			10g. Citizen of What Country?			
r tems 23s	130 WITTOW SLIPEL 11. Marital Status 12. Was Decedent Ever in U.	185	· -	ecity Ves or No-	United	States e - American Indian,		
by Br.	3 ☐ Widowed 4 ☐ Divorced	If Yes, specify Co	M Hispanic Origin? (Spuben, Mexican, Puerto to Specify:	Rican, etc.)	Specify	k, White, etc.		
"natural", ocal Eu	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occ (Give kind of work don life. DO NOT use reti	cupation ne during most of work	ing	16b. Kind of Bu			
than than omp	Elementary/Secondary (0-12) College (1-4or 5+) 1 2 17. Felher's Name (First, Middle, Last)	Seamstress				thing		
f Health and Mental High them 27 is marked other other traumatic event,	Harry Wheatley		18. Mother's Nam	Barrett	Meiden Sumem	θ)		
and Ments is marked sumatic events or To E	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stre			r, City or Town,	State, Zip Code)		
Item 27 i	Salvatore J. Occhipinti	Same as 10		*				
	1 Burial 2 □ Cremation 3 □ Removal from Stele	Piece of Disposition (Name of cemetery, cremetory or other p		Dele	20c. Location - Scranto	City or Town, State		
Department in important: If any injury or once.	4 Donation 5 Other (Specify) Cat 21. Signature of Funeral Service Ucensee	chedral Cemete	y	-2-97	Pennsy			
Departm importar any inju	Da. 14/ 11.00		. Golden F					
	23a. Part1. Enter the disease, or complications that caused the deelt shock, or heer failure. List only one cause on each line.	h. Do not enter the mode of d	ware Street	et, Dur	nmore, P	Approximate		
hysician /Medical xaminer		or as a consequence of):	Hock			Interval Between Onset and Death		
anding physician and usa as the bunal-transit in/Medical Examiner	if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury c. Acute	res a consequence of): 77 YOCARDIA		Acu		DAYS		
ending physician and r usa as the bunal-transit an/Medical Examir	resulting in death) Last	res & consequence of):	DISE	ASE"		YEARS		
ste has been signed by the atterpage 2 should be detached for use of the completed by Physicial	Pert II. Other significant conditions contributing to death but not result the significant conditions contributing to death but not result.					tributa to the causa of death?		
page 2 should be completed 1	MITRAL VAINE REPL	906 MENT		24a. Was a perform	in autopsy med?	24b. Were sutopsy findings available prior to completion of cause of death?		
certificate ha	DE Was one referred to medical			1□ Y	es 200 No	1 ☐ Yes 2 ☒ No		
	25. Was case referred to medical examiner? 10 Yes 2 No Hospitai: 1 Inpatient 2 I	ER/Oulpatient 3 DOA	28. Place of Death Other: 4 Nursing Ho			r (Engelha)		
frer th ineral	07 14 (0)	28b. Time of lnjury 28c. fnj			ow Injury occurre			
is after death. st Director: After the funer and in by the funer. Certification:	3 ☐ SuicIde 6 ☐ Could not be determined 28e. Placa of Injury - Al hor building, etc. (Specify	me, farm, street, fectory, office	9	28f. Location (SI City or Town	treet end Numbe n, State)	er or Rural Route Number,		
he Funer pletely fill edical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my know 2 ☐ Medicaf Examinar: On the best of examinati and manner stated.	wledge, death occurred at the tion and/or investigation, in my	time, date end place, a opinion, deeth occurr	and due to the ca	ause(s) and mar ate and piaca, a	nner as stated. nd due to the cause(s)		
Tota	29b. Signature end title of certifier	29c. Licer	nse number	2	9d. Dale signed	(Month, Day, Year)		
5	30. Name end address of person who completed cause of death (Item					8, 1997		
	DR. THOMAS MILITANO. 76,	10 CARKOIL	AUE. TA	Koma :	Park m	15.20913		
State Registrar	31. Date filed (Month, Day, Yeer) 32. Registrar's Signat	ure						
1 16 Rev 6/95	MAY 0 2 1997 ▶ Julia	Davidson-Randell		_				



State of Maryland / Department of Health and Mental Hygiene

14863 Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Deeth **Physician** 1997 APRIL 3:30PM MONICA MARIA PUERTA /Medical 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner CENTER BETHESDA

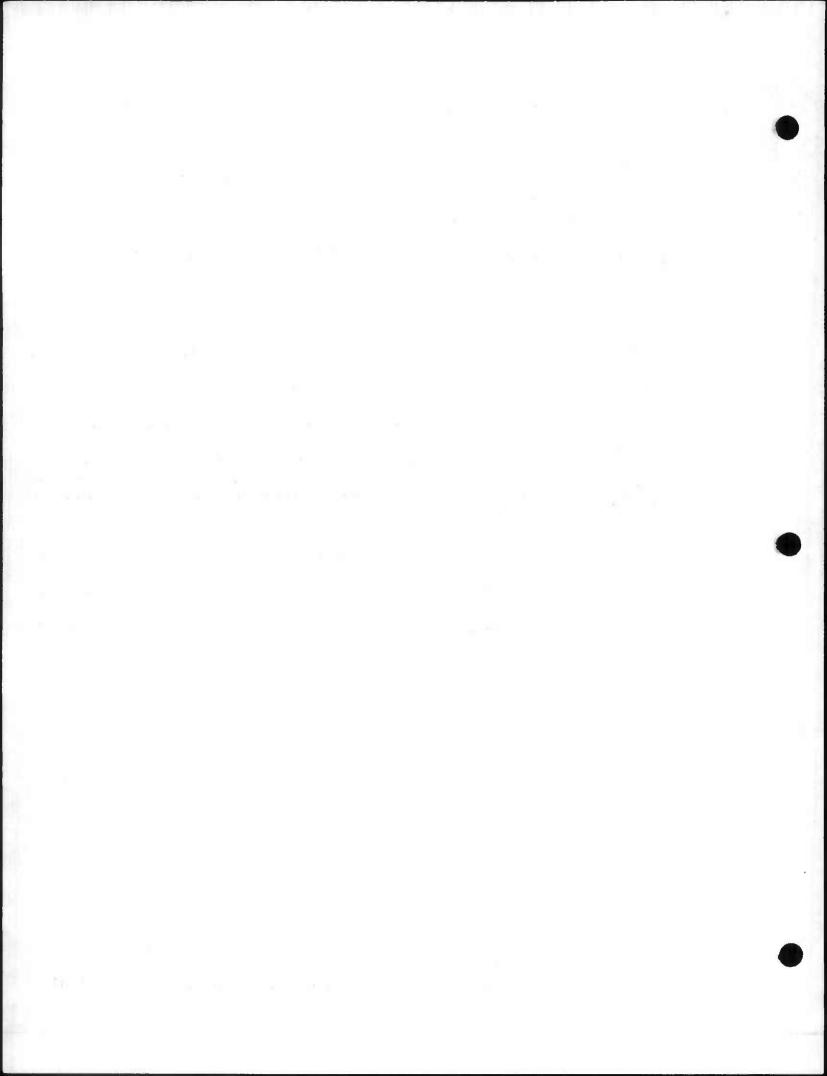
If Under 24 Hrs. 8. Data of Birth
(Month, Day, Year, CLINICAL N.I.H. MONTGOMERY If Under 1 Year Months Deys 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1 □ M 200 F 595-59-5386 23 Director APR.14,1974 COLOMBIA Usuel Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or items 23s or 28s-f show the Medical Examinar must be notified at the Marytar Director Yas 2 No FLA. FT. BROWARD LAUDERDALE 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? REDWOOD WAY 16646 33326 Funerai COLOMBIA 12. Was Decedant Ever in U.S. Armed Forces? 14. Race - Amarican Indian, Black, White, atc. 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Maxican, Puerto Rican, etc.) Never Married 2 Married 1 ☐ Yas 2 🛣 No If Yes, Giva Yeer or Detes: 1X Yes 2□ No Specify: COLOMBIAN Baltimore, Maryland 21215-0020 þ Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygies important: if Item 27 is merked other it any lejury or other traumatic event, the STICE. 12 MAKEUP ARTIST COSMETOLOGY 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be ပ FRANCISCO A. **PUERTA** ADELINA HERNANDEZ 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ITEM #10 SAME AS ADELINA H. PUERTA/MOTHER 20b. Plece of Disposition (Neme of cemetary, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCrametion 3 ☐ Ramovel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 4/29 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signeture of Funerel Sarvice Licensee 22. Name end Address of Fecility 2073 Manuelle M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD 23a. Part1. Enter the disease, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haert failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician Immediete Cause (Finel diseese or condition rasuiting in daath) /Medical CARDIO - RESPIRATORY ARREST Examiner OF OSTEOGENIC SARCOME Due to (or as a consequence of): Examiner PROGRESSIVE PULMONARY METASTASIS physician and the bunal-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaase or Injury that initieted events resulting in death) Last Due to (or as a consequence of): NEOPLASTIC CARDIAC TAMPONADE Box 68760. requires that the death certificate be Physician/Medical Due to (or as a consequence of) 88 980 signed by the a P.0. Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed page 2 s 1 Yas 2 No 1 Yes 2 No director, 25. Was casa referred to medical exeminer? Be 28. Plece of Deeth (Check only one) Hospitei: 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menyar of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 24 hours after death. Funeral Director; After 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Atterview within 24 hours after deserted To the Funeral Director completely filled in by the 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 29e. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and menner as stated. Medical 2 Medical Txaminer: On the besis of exeminetion end/or investigetion, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end mennar stated. 29b. Signature and title of gentiller 29c. Licansa number 29d. Date signed (Month, Day, Year) MD D25757 30. Name end addtess of person who completed cause of death (Item 23a) (Type, Print) 20892 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND HELMAN M.D. 32. Registrate Signature
7 Wha Davidson-Randson 31. Dete filed (Month, Day, Year) State MAY 01 Registrar

State of Maryland / Department of Health and Mental Hygiene

11,861

						Ce	rtificate	of D	eath		Reg. No.	21	1 65	004
	Physic	ian	1. Decedent's Name (First, Middle			7				2. Dete of E		19 ^Y 9a7		me of Death
J	/Medi	cal	An English Name (If not in estimation	Arletta		a Pe	yton	- 1	Oh. Tour	April				00 AM
4	Exami	ner	4a. Facility Neme (If not institution) 11215 Oakleaf		1111			40.		r Location of Dear		nty of Death ntgom		
T	Funeral Director			6. Sex 1 □ M 2 ☐ F	7. Age (In yrs. la			Year Days	If Under 24 Hr Hours Mir		Sirth Year) 2ay, Year) 4 1916	9. Birth		tete or Foreig
			Usuel Residence of Decedent							July	14 1910 Halife			
	how		10a. State 10b. County	_	10c. City,	Town or Le	ocation						10d. Insid	de City Limits
	e Ma	cto	Maryland Montg	omery	Sil	ver S	pring						1 🗆	Yes 2X No
	it 19	Dire	10e. Street and Number				10f. Zip Co				10g. Citizen			
	ath w	ia	11215 Oakleaf					901			United			
21215-0020	within 72 hours after death with the Maryland liene. "nature!" or Nems 23s or 28s-f show the Macrical Examiner Investor in Utled at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	Armed F	2 No)	Was Deceden If Yes, specify 1□ Yes 2□			Specify Yes or Norto Rican, etc.)	lo- 14. F	laca - Ameri Black, White cify: Whi	etc.	in,
0-0	72 hor	pe	15. Decedent	s Education		16a. Dece	dent's Usuai C	occupati	on		16b. Kind of	Business/Ir	ndustry	
21	thin 7	Completed	(Specify only highes Elementary/Secondary (0-12)		(1-4or 5+)		kind of work of DO NOT use	,	ring most of w	orking				
2	filed within Hygiene. ther than	5	12	1		В	ookkeer	-					ar T	abacco
Maryland	o la p	To Be	17. Father's Name (First, Middle, L Ralph W. Tucker			_		1		ame (First, Midd rude All		ame)		
Mar	0 0 0 0		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Meiii	ng Address (S	treet an	d Number or f	Rural Route Num	ber, Cify or To	vn, State, Zi	p Code)	
	CENL		Linda Peyton /	Daughter						703 Silv	-			
Jor			20a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 □Removal from	State		osition (Name matory or othe			Date	20c. Locatio			te
Baltimore,	it. Partmentrant:		4 Donation 5 Other (Sp	-	For		coln Cı			1	Brenty			
Ba	permit. Pages Department of Important: If if eny Injury or once.		21. Signature of Funeral Servica L) Leansee	co					ines/Rir e Ave. S				
	L. II		23e. Pert1. Enter the disease, or shock, or heert failure. List of	complications that	clused the death.	Do not en	ter the mode o	f dying,	such as cardi	ac or respiratory	arrest,	1	Approx	Between
),	Physician /Medical		Immediate Cours /Final										Onset	and Death
	Examiner		Immediate Cause (Finel disease or condition resulting in death)	a. Co	erebral a	rter	ioscler	osis	5				2	years
		ě	,		Due to (or		quence of):					+		
	uted	Examiner		bD;	iabetes]		1.0					<u> </u>	20	years
Ć,	exect in and iel-tra	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	,,,	Due to (or a		quence of):						0.0	
68760,	ysicla	cai	that initiated events	cH	ypertensi Due to (or a		mence of).						20	years
	eath certificate be executed etherding physician and for use as the buriel-transit	Medical	resulting in death) Last		200 (0) (0)	10 a 0011300	1001100 017.							
Вох	th cer endir		Y	d										
	e death he etter	Physician	Part II. Other significant condition	a contributing to	leath but not result	ing in the u	nderlying caus	se given	in Part I.	23b. DI	d tobacco uae	contribute 1	o the car	use of death
<u>О</u> .	that the de ed by the detached	Phy								10	Yes 2 N	3 Pro	bably	4 ⊠ Unknow
ds,	Se De	by	-				-					1 044 14		
Ö	v requir been s should	Completed									is an autopsy formed?	a	vailable p	psy findings prior to n of cause
Records,	S 55	dH										of	deeth?	
	lcian: The la certificate he rector, page									10	Yes 2 No	1	☐ Yes	2⊠ No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical exeminer?	Hospitai:				Other:		eeth (Check onl)				
of		-	1 ☐ Yes 2 ☑ No 27. Manner of Deeth			R/Outpatie		Injury a Work?		Home 5 A Re	sidenca 6 ∐0 e how injury oca		ry)	
o	th. : After s funer	tion	1 ØNeturai 5 ☐ Pending 2 ☐ Accident investiga		of Injury oth, Day Yeer)	Injury	М		s 2□No					
Division	N or Attending selfer death. I Director: After din by the fune	Certification:	3 Suicide 6 Could no determine	ned 289. Plac	a of Injury - At hom ling, etc. (Specify)	e, farm, st	reet, factory, o	ffice			(Street and Nu own, State)	m <i>ber or R</i> ur	al Route	Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (29a. Certifier (Check only one) 1☼ CertifyIng 2 Medical E	xaminer: On the b	e best of my knowl pasis of examination oner stated.	edge, deet n and/or in	h occurred et t vestigation, in	he time, my opin	date end plac ion, death occ	ca, and due to the	e cause(s) and e, date and piac	menner es : e, and due t	stated. to the cau	JSe(s)
	within 2 To the comple	M	29b. Signature and title of certifier	/			29c. L	icense n	umber		29d. Date sig	ned (Month,	Day, Ye	ar)
	5		120 au	13. 1	chuns	Cm	1	0058	91		Apri	1 28,	1997	,
	-		30. Name and address of person w	no completed can	se of death (Item 2	3a) (Type.		- 550			P	,	_///	
			Roger B. Ingham					e, 1	£2400 ,	Riverda	le, Mar	yland	20	737
	Sta	ate	31. Date filed (Month, Day, Year)		Registrar's Signatu		1.0							
	Regist	rar	APR	2 9 1997	Julia	Davidso	n-Randel	20						
DH	MH 16 Rev 6/9	5												

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 14865 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Year ENWALD APRIL 199 10:30 pm /Medical 4a. Facility Name (If not institution, give street and num 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Hours Min. B. Date of Birth (Month, Day, Year)

Dec. 23, 1910 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Country) New York **Funeral** 1⊠M 2□ F Yrs. 085-09-7757 Director 86 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28=4 show enty injury or other traumatic event, its Medical Examiner must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits MD 1X Yes 2 □ No Director Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 9409 Elsmere Court U. S. A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 Narried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Foreign Service Officer US Department of State 17. Falher's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Thomas Purcell Ellen Kenny 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret G. Purcell - Wife 9409 Bethesda, MD Elemere Court 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4/28/97 Silver Spring, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenter 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisc. Ave. N.W. Washington, D.C. 20016 Part. Fisher tha disease, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediata Causa (Final Cerebral ischemia and Myocardial Infarction disease or condition resulting in death) Examiner Atherosclerosis generalized physician end s tha burial-trensit Sequentially list conditions, if any, laading to Immediata ceusa. Enter Underlying Causa (Disease or Injury that Initiated evants resulting in death) Last P.O. Box 68760. Physician/Medical Due to (or as a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Orstrombstind bleeding; Atrial fibrillation Records, 24b. Were autopsy findings available prior to completion of ceuse of death? Covousy arkey disease; carolid stemsis 24a. Was an autopsy performed? peed 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No spital or Attending Physistours after death.

neral Director: After this or filled in by the funaral di 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding Investigation Natural 1 Yes 2 No 2 Accidant 3 ☐ Sulcide 6 ☐ Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, straat, factory, offica building, atc. (Specify) 4 | Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the causa(s) and mannar as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. edical 29a. Certifia 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) emel 30. Name and addrass of person who complated cause of death (Item 23a) (Type, Print)

OME

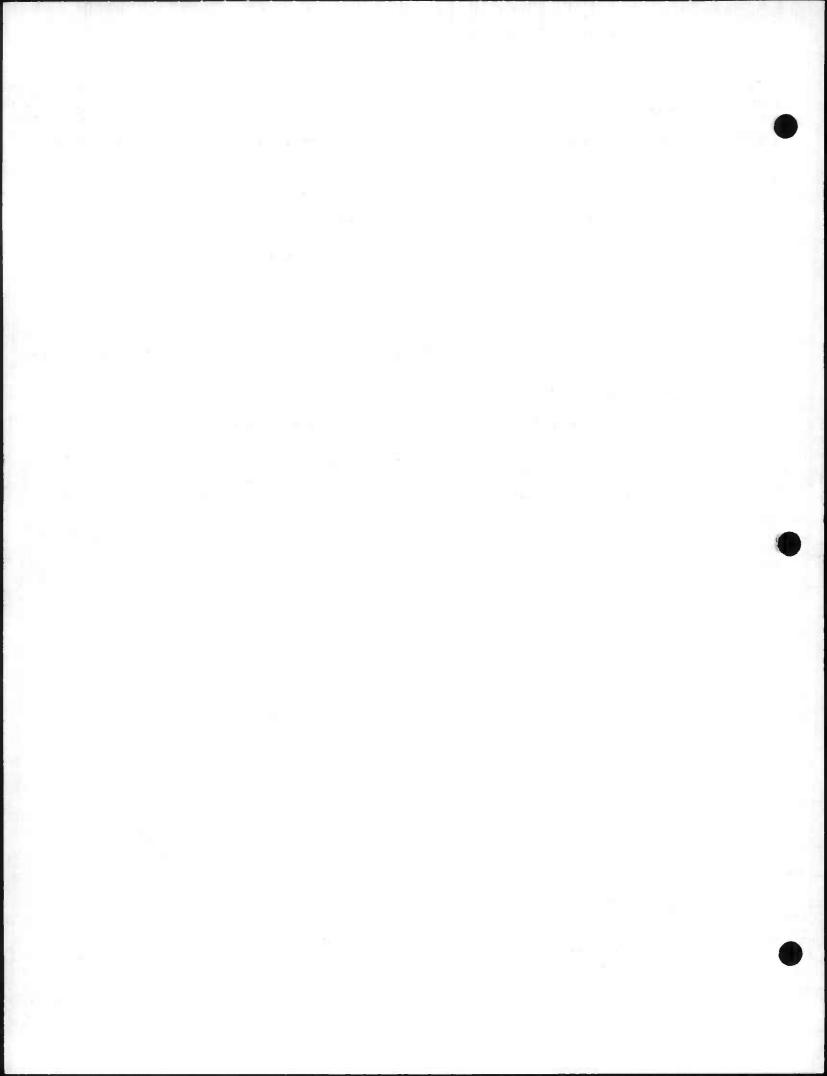
32. Registrates Signature

410 ROCKLEDGE DR. BE

Registrar

State

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

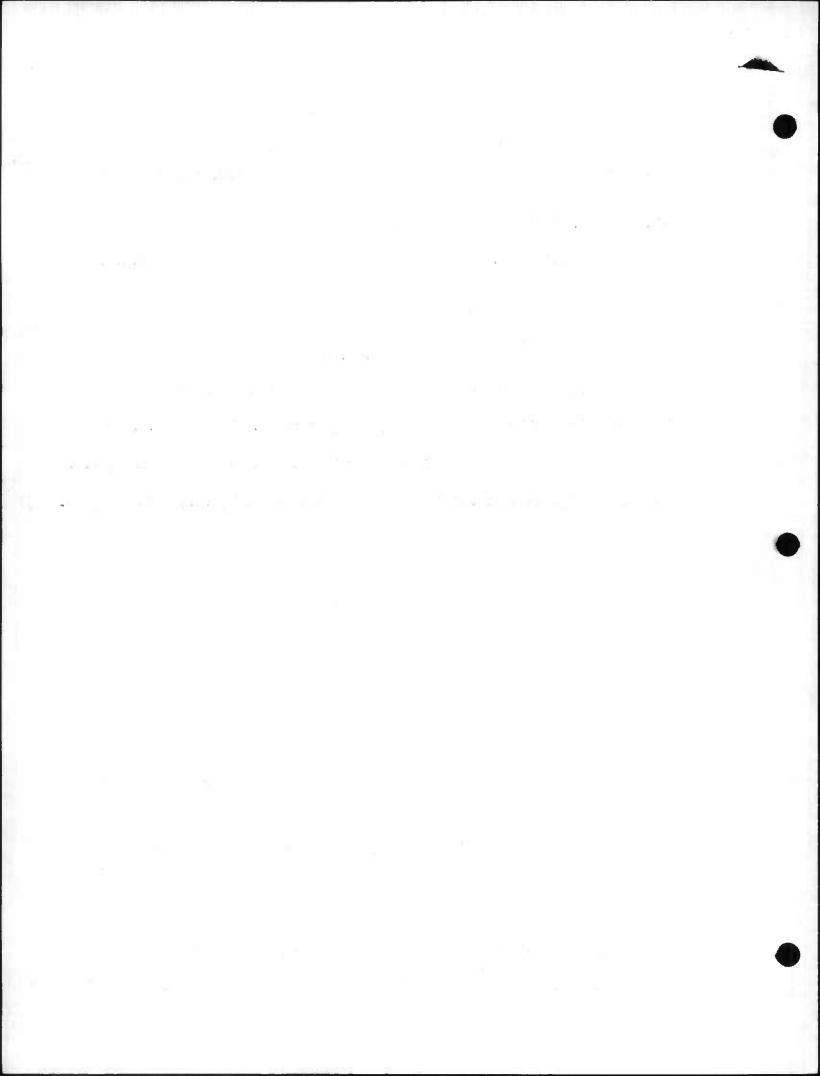
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							Ce	runcate	OI I	Jeatr			Reg. No.			
Physic	ian	1. Decedant's Nam	na (First, Midd	la, Last)								2. Data of D Month	eath Day	Yaar	3. Tima of Death	
/Med		Thelma V	Veadd F	eters									24,199		12:16 AM	
Exami	ner	4a. Facility Nama ('If not institution	n, giva stre	et and num	ber)			4	b. City, T	own, or Lo	ocation of Dea	th 4c. Co	inty of Deat	h	
	, 1	9506 Cle		load					S	ilve	r Spi	ring	Mo	ntgom	ery	
Funeral		5. Social Sacurity N	Number	6. Sax	21€ F	7. Aga (In yrs. la		If Undar 1	Yaar Days	If Unda Hours	24 Hrs. Min.	8. Data of B (Month, D	irth lay, Yaar)	9. Birtl	hplaca (Stata or Foreign untry)	
Director		436-18-0		I I M	280 F	81	Yrs.		.,.			Jan. 8		Lou	isiana	
pu		Usuat Rasidance of	10b. County	,		10c City	Town or Lo	cation	_						10d. Insida City Limits	
ahow	5	Tour orang	iob. Godini			Too. Only,	TOWN OF EC	roa (ioi)							1 ☐ Yas 2 🛣 No	
h the Marylar r 28s-f show	Director	Maryland 10e. Street and Nu	Montg	omery		Si	1ver	Spring								
with the Maryland a or 28a-f show	à	10e. Street and Nu	mber					10f. Zip Co	oda				10g. Citizen	of Whet Co	untry?	
₽ 23	rai	9506 Clem	nent Ro					209						.A		
	Funeral	11. Merital Status			Armed Ford		. 13.	Was Decedan If Yas, specify	Cube	ispanic Oi n, Maxice	igin? (Spe n, Puarto	ecity Yes or N Ricen, atc.)	0- 14.	Hace - Ame Bleck, White	ricen Indian, a, atc.	
	by F	1 ☐ Navar Marr 3 🛣 Widowed			1 □ Yas - 2 If Yas, Giva Year or Dai	1		1 □ Yas 21k) No	Specify	:		Spi	Specify:		
15-00: 72 hours natural;	8	0 00 111001100	15. Deceder			ido.	16a Dece	dent's Usuel (Jacup	ation			16h Kind	ظ /Business t	lack	
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Maryland 21215-0020 d 2 should be filed within 72 hours af th end Mental Hylgene. 7 is marked other than "natural", or traumatic event, the Medical Exerc traumatic event, the Medical Exerc	Ĕ	Elamantary/Seco	ondary (0-12)		Coilage (1-	,		ical N		,			Medic	1		
D High		17. Fathar's Nama	(First, Middla,	Last)			rract	ICAI N	ur s		ar's Nama	a (First, Middle	e, Malden Sur			
d be antal	o Be	John	Weadd													
arylan	2	19a. Informant's N		ship /Type	Print)		19b Mailii	na Addrass (S	itreet :		onti:		aste ber, City or To	wn State 7	Pin Code)	
ges 1 end 2 should be filed to fleeth end 2 should be filed to fleeth end Mental Hyger filtem 27 is marked other or other traumatic event,		Lois M.			,			Clemen								
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State of Maryland / Department of Health and Mental Hygiene					

	Amende	d ‡	‡7, 4/29/97, JW,				artment of rtificate of		nd Mental Hy	giene (97	14867
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Baltimore,	permit. Pag Department Important: I any Injury o		21. Signatura of Funaral Sarvice Li	cansee		22	. Name and Addr	ass of Facility				
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State of Maryland / Department of Health and Mental Hygiene

				C	ertificate of	Death	Reg	g. No.	1 140	000
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		5. Social Sacurity Number 6. Sax	T. Age (In yes	S birth	av) If Undar 1 Year	If Undar 24 Hrs.	N Date of Dist	PRINC		ges
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with the	Funeral Director	10e. Street and Number 8919 Santeetlah			10f. Zip Code	735	100	g. Citizan of What	t Country?	
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s effer i Dire od in b	Certification:	4 Homicida datarmined	building, atc. (Specify)			City or Town, S			
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19)	1	30. Nama and address of person who com	WUM	02017		ーレイノ	//	7/2	-794	
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						Cert	ificate of	f Death		Reg. No.	- 1	1 4000	,
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-		The l	2712 SHAWN COI 5. Social Security Number 6. S	URT 7. Age (In yr:	lost hirt	thday)	If Undar 1 Yas	FORT V	ASHING 8. Date of B n. (Month, L	TON PR	INCE	GEORGES plece (State of Foreign	_
	Funeral Director			25 M 2□F		Yrs.	Months Dey	s Hours M	n. (Month, E	Day, Year)	Cou	ntry)	,
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	yland		10a. Stete 10b. County	10c. C	ity, Town	or Loca	ation					10d. Inside City Limits	
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	r 284	rec	10e. Street end Number				10f. Zip Code			10g. Citizen of	Whet Cou	ntry?	-
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or ferms 23a or 28a-f show ont, the Medical Examinet must be notified at	Funeral Director	2712 Shawn	Ct.			20	744		Ţ	J.S.	Α.	
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07	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		11	□Yes 2⊠N	o Specify:		Specil	y: B.	lack	
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a	Ald by Al	ToE	Harry A. Pear	son, Jr.				Joan	n C. Ja	mes			
Maryland	should and Men marke umaric		19e. Informant's Neme/Relationship (7	Type, Print)	19b.	Meiling	Address (Stre	et end Number or	Rural Route Num	ber, City or Town	, Stete, Zij	p Code)	
	and 2 selth a n 27 is		Harry A. Pears	on.Jr./Fath	er		Same a	s # 10	above				
re	oth oth		20e. Method of Disposition	20b.	Piece of	Disposi	tion (Neme of		Dete	20c. Location	- City or T	own, Stete	_
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L C	leath. lor: After th the funeral	lon	27. Menner of Deeth 1 □ Neturel 5 □ Pending	28e. Dete of Injury (Month, Day Yaar)	28b. T	ime of	28c. lnj W		28a. Describe	how injury occur	+-	-e/ [24.74	1
vision of	Attending or death. ector: After by the fune	rtification:	2 Accident Investigetion 3 Suicida 6 Could not be	10011	07	108		Yes 221No	300	ca of	24 0	400011	
2	frer d free d lirect in by	ŧ	4 ☐ Homicide determined	28e. Place of Injury - At in building, etc. (Spec	nome, ter	m, stree	a, tactory, office	9	City or To	(Street end Numi gwn, State)	d I	ai moute Number,	

To the Hospital or Att within 24 hours efter d To the Funeral Direct completely filled in by 1

Medical Certif

State Registrar

29e. Certifier (Check or one)

29b. Signature a

31. Dete filed (Month, Day, Year) APR 2 9 1997

111 Penn Street, Baltimore, Maryland 21201

HOME

(Item 23e) (Type, Print)

1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner es steted.

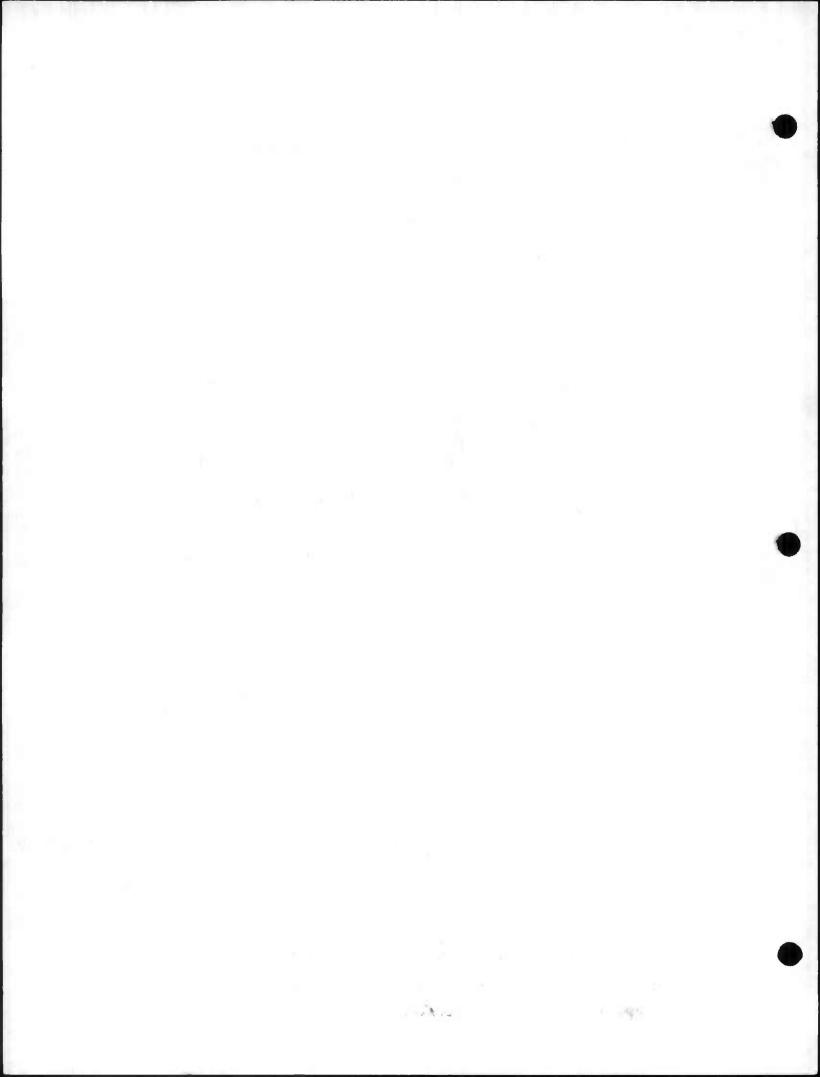
Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the ceuse(s) end manner stated.

29c. License number

O.C.M.E.

29d. Dete signed (Month, Dey, Year)

APRIL 26, 1997



1		-	FOR STATE REGISTR	A
,	1.	D	ECEDENT'S	A

	1 - STATE REGISTRAR	SIATE UP MA			F DEATH	MENTAL HYGI REG.					
	1. DECEDENT'S NAME (First, Middle, Last)	acie Pa	rrish			2. DATE OF DEATH		YEAR 97	3. TIME OF DEATH 7:00 A M		
9	4. SOCIAL SECURITY NUMBER 115-30-7671	5. SEX 6.	AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Yea 8-4-16		8. BIRTHP Country)	inginia		
TOR		et and number) ail Rd.			n or location of er Marlbo			nce G	HTA		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE Maryland Princ	e George		y, town on Lo					10d. INSIDE CITY LIMITS?		
L D	10e. STREET AND NUMBER	e deol ge	Тор	per Mai	100 CODE		40- CI		YES 2 NO		
FUNERAL	8701 Grey Fox Tra	il Rd.			20772		US		IAI COONTRIT		
B⊀	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 I IF YES, GIVE WAR	YES 2 NO	If yes,	DECENDENT OF HISP specify Cuban, Maxi (ES 2 X) NO Spe	ANIC ORIGIN? (Specify can, Puarto Rican, atc. offy:	Yes or No	14. RACE - Black, Specify:	- American Indian, Whita, etc.		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co Elementary/Secondary (0-12)	TION empleted) College (1-4 or 5+)	life. Do NOT u	work done during	most of working	18b. KIND OF BUSINESS/INDUSTRY GOVERNMENT					
BE COM	17. FATHER'S NAME (First, Middle, Last) Frazier Britt				18. MOTHER'S	Johnson					
TO B	190. INFORMANT'S NAME (Type/Print) William Rogers					pper Marl			20772		
	20e. METHOD OF DISPOSITION 1		206. PLACE AND DATE	of disposition	(Name of Cemetery 5	-3-97 G	oochla	and, Vi	rginia		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE MA	tee-	22. NAME	AND ADDRESS OF	FACILITY Univery St,N.W.	rsal N	1ortua	ry Inc.		
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) E. Possible Sepsis Due to (OR AS A CONSEQUENCE OF): Detail if us Due to (OR AS A CONSEQUENCE OF): Due to (OR AS A CONSEQUENCE OF): Due to (OR AS A CONSEQUENCE OF): Due to (OR AS A CONSEQUENCE OF):										
MEDICAL	PART II. Other algorificant conditions Pornible Present	onia				PER	AN AUTOPSY FORMED?	0	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? VES 2 - NO		
PHYSICIAN:	DID TOBACCO USE CONTRIL 26. WAS CASE REFERRED TO MEDICAL	BUTE TO CAUS	26. PLACE OF DEA			IN 🗆					
SIC		OSPITAL:	R/Outpatient 3 □ DOA	OTHER:		6 Other (Specify)	Care	Home			
BY PH	27. MANNEB OF DEATH 1 Hetural 5 Pending 2 Accident Investigation	28e. DATE OF INJ (Month, Day,		IURY	INJURY AT WORK?	28d. DESCRIBE HO					
	3 Suicide a Could not be 28s. PLACE OF IMPR — At home, farm, streat, factory, office 28s. LOCATION (Street and Number or							or Rural Rou	ute Number,		
COMPLETE	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:								and menner ea stated.		
BE	20b. SIGNATURE AND TITLE OF CENTIFIER	Penane	l mn		29c. LICENSE N	UMBER	29d. DA	TE SIGNED (1	Aonth, Day, Year)		
٥	30. NAME AND ADDRESS OF PERSON WHO C	1	,	Print) = 103	Coo	then "	uel	2111			
APR 29 1997											

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the formatter death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev t/89

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State of Maryland / Department of Health and Mental Hygiene

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					Cei	rtificate o	f Death			Reg. No.	2 1	1 40 / 1
Dhambal		1. Decedent's Name (First, Middle, I							2. Date of Do		Vee	3. Time of Death
Physici /Medic		Alpho	nso	Pollard					April	Day 9 1	Yeer 997	3:48 PM
Examir		4a. Fecility Neme (If not institution, g	ive street end n	umber)			4b. City, To	wn, or Lo	cation of Dea			5.40 111
		University of	Maryla	nd Hospi	tal		Bal	timo	re			
uneral			Sex 1☑M 2□F	7. Age (In yrs. I		If Under 1 Ye Months Day	ar If Under	24 Hrs. Min.	6. Dete of Bi	rth ey, Year) y 2, 1949	9. Birthp	place (State or Foreign
irector		229-64-4870	IXIM ZUF	4	8 Yrs.				Januar	2, 1949		ginia
3		Usual Residence of Decedant 10e. State 10b. County		10c City	, Town or Lo	cation						
ohs a	ក	District of Col	umbia	100. 01.9		<i>l</i> ashingt						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
288-	ect	10e. Street end Number	diiibTa			10f. Zip Code				10- 01	140-110	Λ
9 8	ā	5319 E St., S.E	. #957			Tot. Zip Code	2001	0		10g. Citizen of		
copatition or result and western registration in the mass 23a or 28a-f show any injury or other traumatic event, the Mass call Examinet must be notified at 200s.	Funeral Director	11. Maritel Status		cedent Ever in U,S	S 12 1	Was Decedent of			noifu Vac or N		ed St	cates can Indien,
Tree Tree	Fun	1 Never Married 2 Married	Armed F	orces?	10.1	f Yes, specify C	uban, Mexicar	, Puerto	Rican, etc.)	Bia	ck, White,	
II, o	by	3 ☐ Widowed 4 ☐ Divorced	tf Yes, G Yeer or I	ive A		1□Yes 2∏(N	lo Specify:			Specif	y: B	lack
salls	8	15. Decedent's	Education		16a. Deced	dent's Usual Occ	upation			16b. Kind of B		
n n	Completed	(Specify only highest g Elementary/Secondary (0-12)		(1-4or 5+)	(Give life. L	kind of work do DO NOT use ret	ne during mos: ired)	t of worki	ing			
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vent	Be C	17. Fether's Name (First, Middle, Las	it)					r's Name	(First, Middle	, Meiden Sumer	-	
tic e	ToE	Mur	riell Po	ollard				May	Mary B	erkley		
E I		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Addrass (Stre	et end Numbe	er or Rura	A Route Numb	per, City or Town	Stete, Zip	Code)
127 er tri		Delois Pollard-Wilts	hire/Daug	hter	531	9 E St.	, S.E.	#9	57, Wa	shington	, D.	C. 20019
roth		20a. Method of Disposition			eca of Dispo	sition (Name of netory or other p			Date	20c. Location		
ury o		1 ☐ Burial 2 🂢 Cremation 3 4 ☐ Donetion 5 ☐ Othar (Spec		State	Lee's	Cremat	orv	4	/30/97	Clin	ton,	MD
any Inj		21. Signature of Funeral Service Lice	enson	0		. Name and Add				Funeral		
2 2		John T.	Thurs	TIT	4	001 Ben	ning R					D.C. 20019
		23a. Part I Entar the disaasa, or conshoot, or heert failure. List onl	nplicetions that	caused the daeth								Approximete
sician		SINCE, OF HEER TAILUIS. EIST OFF	y one cause on	Bach IIIIB.							1	Interval Between Onset and Death
dical		Immediata Causa (Final disease or condition		Sepsis							1	7 days
niner		resulting in deeth)	a		es a conseq	uance of):						/ days
.=	ner											
trans	Examiner	Sequentially list conditions,	b	Due to (or	as a conseq	uenca of):						
-BOD		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury										
the	/Medical	that initiated events resulting in death) Last	0.	Due to (or	as a consequ	uence of):						
iong physician and ise as the burial-transit	Me		d									
for u	lan										į	
hed	Physician	Pert II. Other eignificant conditions	contributing to d	leath but not resul	iting in the ur	iderlying cause	given in Part I.		23b. Did	tobacco uae co	ntribute to	the cause of death?
be detac									1 🗆	Yee 2 No	3 Prot	bably 4 Unknown
ed b	d by								04-144-	CATHODISCO T	04h 18/4	ara autanau findiana
should	ete									en eutopsy ormed?	eve	era autopsy findings ellable prior to mpletion of cause
N .	Completed											death?
r, page									10	Yes 2X No	10	J Yes 2⊠ No
	m	25. Wes case referred to medical exeminer?	الله Hospital: کے					of Death	(Chack only	one)		
	2	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 12	Inpatient 2 E		1 3LI DOA		-		Idence 6 Oth		(V
fune	Certification:	1 Natural 5 □ Panding		th, Dey Year)	28b. Tima of Injury	28c. In W	juryat /ork? □Yes 2□t		28d. Describe	how injury occur	red	
f in by the fune	Ical	2 ☐ Accident investigation 3 ☐ Suicida 6 ☐ Could not	00 000	of Injune. At hor	me form str				19f Looption	Straet end Numb	or or Dues	I Doute Atumber
lin by	E	4 Homicide determined	build	of Injury - At hor ing, etc. (Specify))	et, lectory, onic	6	4		wn, Stata)	er or mura	r noute Number,
filled		29a. Cartifier 1 Certifying P	hvetcien: To the	best of my know	ledes death	occurred at the	time date and	d piece e	and due to the	course(s) and me		halad
letely	edical	(Check only 2 Medical Exa	miner : On tha b	asis of examination	on and/or inv	estigation, in my	opinion, deat	th occurre	ed at the time,	date and place,	and dua to	tha cause(s)
completely filled	SEC.	29b. Signature and title of certifier				29c. Lice	nse number		4	29d. Date signe	d (Month, I	Dey, Year)
-		Terr	0				00866	1				1997
	-	30. Name and address of person who	completed com	se of death floor	230) /Time 1							
/		TODA S.	('ROCE	1.71	238) (1ype, 1 Umm S		5. Givee	me St	t Ray	timore,	MA 2	21201
Stat	e	31. Dete filed (Month, Day, Year)				,						,
Registra		APR 30 199	404	legistrar's Signatu	Madel							
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Vear **Physician** Earnest April Parham 1997 /Medical 15:15 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MANOR CARE SERVICE CHEVY CHASE
If Under 1 Year If Under 24 Hrs. 8, D. MONTGOMERY COUNTY 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpiace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1⊠M 2□ F Months Days Hours Yrs. Director 579-48-4060 76 VIRGINIA JULY 1, 1920 Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Items 23s or 28s-f short iner must be notified at Director 1X Yes 2 No WASHINGTON, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4436 KANSAS AVENUE, N.W. UNITED STATES 20011 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 XYas 2 No If Yes, Give Year or Detes: 1 Never Married 2 Married 21215-0020 natural', or 1 ☐ Yes 2 ▼ No Specify: Specify: ð BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Depertment of Health end Mental Hyglene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Medis. 2008. Elementary/Secondary (0-12) College (1-4or 5+) DRIVER INTERNATIONAL BANKING Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Surname) Be EARNEST PARHAM ERMA BONNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) CHRISTINE PARHAM, DAUGHTER 4436 KANSAS AVE., N.W., WASHINGTON, D.C. 20011 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cramation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) EPIPHANY CHURCH CEMETERY 5/2/97 | FORESTVILLE, MD 21. Signature of Funerel Service Licensee 22. Name and Address of Facility FORT LINCOLN FUNERAL HOME 23a. Part 1. Enter the disease, or complications that disead the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseasa or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last attending physicien end for use es the buriel-trer Due to (or es a consequence of) Box 68760. Physician/Medicai the Due to (or as e consequença of) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by I 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy completion of causa of death? page 2 s 1 ☐ Yas 2 ☐ No 1 Yes 2 No certificate Division of Vital Hospital or Attending Physician: 24 hours effer deeth. Be 25. Was casa referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 21 No 2 1 Yes this 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Natural s efter deeth.
I Director: Aft
d in by the fur 1 Yes 2 No Cone 2 Accident 6 Could not be determined 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours eff To the Funeral DI completely filled in 11 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Neme and address of person who completed ceuse of death (Item 23a) Type, Print) H. ROBERT BIRSCHBACH, M.D., 6320 DEMOCRACY BLVD., BETHESDA, MARYLAND 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Data of Death 3. Time of Deeth **Physician** Month Lucy Pollio 30, 1997 3:13 A.M. April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Lanham Prince George's ff Undar 1 Yaar | If Undar 24 Hrs. | 8. Date of Birth Months Days | Hours | Min. | (Month, Day, Ye 5. Social Security Number 7. Age (In yrs. last birthdey) Birthpiace (State or Foraign Country) **Funeral** 1 M 201 F Sept. Director 142-05-5475 86 Yrs 27,1910 New Jersey Usuat Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 Yes 2 No Maryland Prince George's Suitland 10e. Street and Number 10f. Zip Coda 10c. Citizen of What Country? 6 items 23a 4509 Navy Day Place U.S.A. 20746 death by Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No tf Yas, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, atc. Peges 1 and 2 should be filed within 72 hours after of health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or item
arry or other traumatic event, fire Medical Examme.
arry or other traumatic event, fire Medical Examme. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 □ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Communications Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Unknown Unknown Jennie 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) Fr. John Dakes/Personal Rep. 2400 Brooks Drive, Suitland, Maryland 20746 20a. Method of Disposition

VXBuriat 2 ☐ Cremation 3 ☐ Removal from Stata 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State permit. Pege Depertment of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 5/2/97 Suitland, Maryland Cedar Hill Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
George P. Kalas Funeral Home se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, List only one cause on each line. 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 Approximata Interval Betw Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner sician end buriel-trensit eumania The law requires that the death certificete be executed Sequentially tist conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury Due to (or as a consequenca ot): Meast failure P.O. Box 68760. stine ma Physician/Medical that initiated events resulting in death) Last for use es the Due Je (or as a consequenca of): ate hes been signed by the a pege 2 should be deteched Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Prunknown Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate hes 1 ☐ Yas 2X No 1 ☐ Yes 2 ☐ No of Vital ual or Attending Physician: The effer death. Be 25. Was case referred to medicat 28. Place of Death (Check only one) Other: 4 Nursing Home 5 1 Rasidence 6 Other (Specify) Certification: To 1 Yes 2₩ No 1 ☐ Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation Division 1 Matural 1 Yes 2 No the 2 Accident 6 Could not be determined 3 Sulcide in by 28e. Ptaca of Injury - At home, farm, streat, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital within 24 hours or To the Funeral Completely filled Hospital 29a. Certifian 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basts of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of cartifier 29c. Licensa number 29d. Date signed (Month, Day, Year)

(8)

State Registrar 31. Date flied (Month, Day, Year)

MAY 01 1997

30. Name and address of person who comptated cause

32 Registar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14874 Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middia, Last) 2 Data of Death 23 9 4c. County of Dee Nama (If not institution, giva street and numbar) Town, or Location 0 rusp 5000 MOU 5. Social Security Number 6. Sax Undar 24 Hrs. Birthplaca (Stata or Foreign Country) If Unde Months 8. Date of Birth (Month, Day, Year) Days Hours 1 M 2 F 100-09-0873 83 Jan. 5, 1914 New York Usual Rasidance of Dacedant 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☑ No Maryland Silver Spring Montgomery 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2011 Glen Ross Road 20910 U.S.A. 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No 13. Was Decedant of Hispanic Origin? (Specity Yas or No-II Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11 Maritai Status 1 Navar Marriad 2 Marriad 1 ☐ Yas 2 ☑ No Specify: Yas Giva Specify. 3 ₩ Widowed 4 Divorced Year or Dates White 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usuai Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working life. DO NOT usa ratired) Eiamantary/Secondary (0-12) Coilega (1-4or 5+) Real Estate Agent Real Estate 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middia, Meidan Sumama) Calogero Dimino Maria Ciulla 19a. informant's Name/Ralationship (Type, Print) 19b. Maliing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Charles D. Reed 2313 Arcola Avenue Silver Spring, Maryland 20902 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cramation 3 ☐ Ramovai Irom Stata 4 ☐ Donation 5 ☐ Othar (Specify) 4/28/97 Silver Spring, Maryland Gate of Heaven Cemetery 21. Signatura of Funaral Sarvice Licensag 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 23a. Part 1) Enter the disease, or complications the caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, Approximate Approximate Approximata intarvai Between Onset and Death Immediata Causa (Finai disaasa or condition resulting in daath) Due to (or as a consequance of):

Physician /Medical Examiner

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After

Attending

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Hospital or Attendi
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 Funeral Director: A

To the Hospital within 24 hours a To the Funeral D

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Certification:

Medical

certificate be executed physician and s the burial-trans

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

10a. Stata

12

Funeral

Director

r 28a-f show show

r than "natural", or items 23s or the Medical Examiner must be

Director

Funeral

à

Completed

Be

with the Maryland

death

filed within 72 hours after

i Hygiene.

permit. Pages 1 and 2 should be in Department of Health and Mental Important: If Itam 27 is marked of

other traumatic event,

ò injury

any ir

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated avents resulting in death) Last Physician/Medical

Dua to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Wara autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yas 2 No

25. Was casa relarred to medical axaminar? 2 No 1 ☐ Yas

26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidance 8 Othar (Specify) 2 ER/Outpatient 3 DOA 1 Inpatiant 28a. Data of injury (Month, Dey Year) 28d. Dascribe how injury occurred 28c. injury at Work?

27. Manner of Death 1 Natural 2 Accident 3 Suicida

4 Homicide

5 Panding investigation 6 Could not be detarmined

1 Yes 2 No 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

2 1 No

1 Yas

29a. Cartifiar (Check only one)

1 Certifying Physician: To tha bast ol my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and mennar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

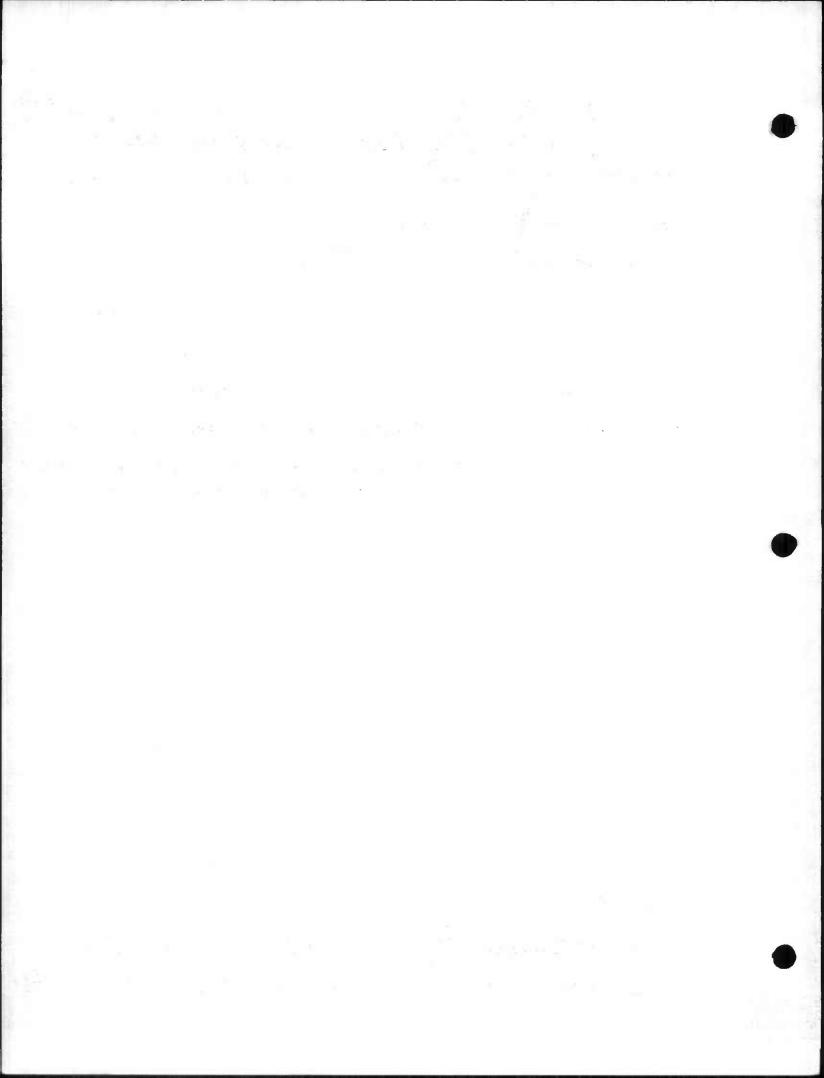
30. Nama and addrass of person who complated causa of death (item 23a) (Type, Print)

Hospital:

31. Data Hied (Month, Day, Year)

32. Ragistrar's Signatura

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4875 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Year Jeffrey M. Robbins 23:40 April 24 1997 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RA. Crowley Shock Trauma anter Baltimore BALTIMORE 6. Sex 1 M 2 □ F 7. Age (In yrs. lest birthday) If Undar 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Dey, Yeer) 5. Social Security Number 9. Birthplace (State or Foreign Days WASHINGTON, DC 214-60-1964 33 January 26, 1964 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5808 INMAN PARK CIRCLE #100 20852 UNITED STATES 12. Was Decedent Ever in U,S Armed Forcas? Was Decedent of Hispanic Orlgin? (Spacify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) Race - American Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 ☐ Yas 2 X No If Yes, Give Year or Datas: 1 ☐ Yes 2 A No Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ATTORNEY 5+LEGAL 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) JAY HOWARD ROBBINS JOAN LINDA RAFF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JOAN LINDA RAFF ROBBINS (MOTHER) 8209 GAINSBOROUGH CT.-W. POTOMAC, MARYLAND 20854 20b. Place of Disposition (Neme of cemetery, crametory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State JUDEAN MEMORIAL GARDENS 4/30/97 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPLES, INC. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, of complications that causad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852 Approximete Interval Between Onset and Death Immediate Cause (Final Brainstem injury (eight) hours disease or condition resulting in death) Due to (or as a consequence of). Atlanto - occipital dislocation Sequantially list conditions, if any, leading to Immadiate ceuse. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Last Due to (or as e consequence of): Due to (or as a consequence of): rt I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 SNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

Department of important: If any injury or

Physician

/Medical

Examiner

10a. State

Funeral

Director

"natural", or items 23s or 28s-f show ad call Examiner invest be notified at

Pages 1 and 2 should be filed within 72 hours after death vinent of Health and Mental Hygiene.
Int. If them 27 is marked other than "natural, or items 23.
Int. or other traumatic event, the Modical Examinar rivual.

21215-0020

Baltimore, Maryland

P.O. Box 68760,

Records.

Division of Vital

The law requires that the death certificate be

signed by It Id be detach

this certificate has

spital or Attending Physicien: The hours after death.

neral Director: After this certificate y filled in by the funeral director, pa

Hospital of 194 To the Hospital within 24 hours a To the Funeral L Directo

Completed by Funeral

Be

the Maryland

Physician/Medical Examiner by Completed Be 2 Medical Certification:

art il. Other significant condit	tions contributing to death	but not resulting In t	the underlying cause	given In Par

1 Yes 25. Wes cese referred to medical 26. Piace of Death (Check only one) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA res 2□ No Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify)

nus

1 Yas > No

28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 5 Pending investigation 1 Naturai 2 Accident April 26, 1997 16:00 3 Suicide 6 Could not be

1 Yes 2 No

28d. Describe how injury occurred motorcycle accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide street 29a. Certifier

Location (Street and Number or Rural Royle Number, City or Town, State) Rt 28 at Jerusalem Rd Belfville 1) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as steted.
2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of cert

29c. Licensa number 09061

29d. Date signed (Month, Day, Year) April 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street South Greene

Baltmore 21201 mp

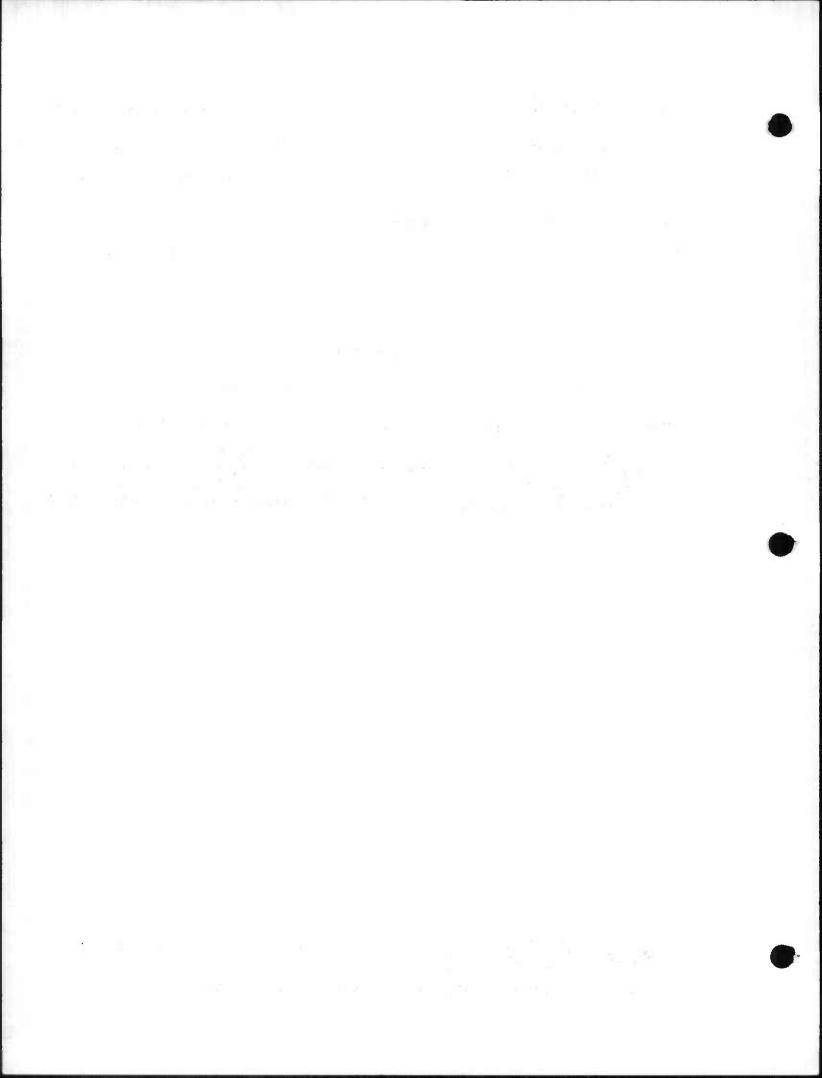
State Registrar

32. Registrar's Signature 31. Date filed (Month, Dev. Year) APR 2 8 1997

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	Examir		4a. Facility Nama (If not inst	tution, giv	e street and n	umber)				4b. City, To	own, or L	ocation of Death			7 120111	
			17504 Redlar	d Ro	ad				1	Derwo	od		Mont	comer	V	
Т	Funeral		5. Social Security Number	6. 5			yrs. last birthd	Months	1 Year Deys	if Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da			aca (State or Foreig	n
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Maryland 21215-0020	6 世世 華	1	19a. Informant's Name/Rela			- >						al Routa Numbe		, Ststa, Zip	Code)	
	ges 1 an t of Heal If Item 2 or other	ŀ	Charles C. F	lead_	(Husbar		175(Ob. Place of Di			Rd.	Derw	ood, Md	. 20855 20c. Location	City or To	um Plata	
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19			Dary	m.	Ysi	u						Dr. Gai		rg,Md		
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ó	be executionand iclan and burial-tran	EX	Sequentially list conditions, if sny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that inflated events													
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		/sic	Part II. Other significant cor	ditions o	ontributing to d	leath but no	t rasulting in the	undarlying ca	ausa giv	an in Part	i.	23b. Did 1	obacco use co	ntribute to	the cause of death	?
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Records,	requiras that the een signed by th hould be detach	d by										Ode Wee		Dah Ma	ra sutopsy findings	_
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ā	a afte	Certification:	4 ☐ Homlcida		build	ling, atc. (S	pecify)					City or Tov	vn, Stata)			
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	To the Hospital or Attending Ph within 24 hours after death. • To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only 2 Med one)	icai Exan	niner: On tha b and mer	nasis of exa	mination and/or	invastigation,	in my o	plnion, dae	oth occur	red at tha tima,	data and piaca,	and dua to	the cause(s)	
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	8		1 dere	el >	XL	ere		D	C-1	8561			April	25, 1	997	
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			David J. Perm							ngton	D.C	. 20010				
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	Registr	all	AP	K Z E	3 1997	100	- Thursday	100								



State of Maryland / Department of Health and Mental Hygiene

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						C	ertificat	e of	Death		Reg. No.	21	1407
			1. Decedent's Name (First, Midd	lle, Last)			¥*.			2. Dete of D	eath	W	3. Tima of Death
	Physic		Lilli	a Bogash	R	obbin	S			April	22, 19	Year 997	1:00 P.
) at	/Medi Exami		4a. Facility Name (If not institution					3	4b. City, Town, o	Location of Dea		of Death	
			Shady Grove Ad	ventist Nur	sing	Cente	r		Rockv	ille	Mon	ntgom	erv
	Funeral		5. Social Security Number	6. Sex 7. A	Aga (In yrs.			1 Year Days	if Undar 24 Hr Hours Mir	s. 8. Date of Bi	irth		place (Steta or Forai
	Director		220-01-7973 Usual Residence of Decedent	1□ M 22 F	87	Yrs.	Working	Days	Trours	Oct. 2		Cali	fornia
	osath with the Maryland the 23s or 28s-f show If must be notified at	2	10a. Stata 10b. County			y, Town or						1	1 M Yes 2 N
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	0 K	급					10f. Zip	Code			10g. Citizen of	what Cour	ntry /
	e 23	era	333 Little Quar	rry Road	A Francis III	6 4	2 Mar Dans	208		Onneit - Van an N	United		ean Indian.
_	or its	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mai 3 □ Widowed 4 ☒ Divorced	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give	s? ₫No	,5. 1	if Yes, spec			Specify Yas or N into Rican, etc.)	Bla Specif	ck, Whita,	etc.
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Maryland	s 1 and 2 should be filed f Haalth and Mantal Hygi ftam 27 is marked other other traumatic event, I	မ	Louis 19a. informant's Name/Relation		asn	19h M	ilina Address	(Street	and Number or F	raillly Rural Routa Numi	Dinah ber City or Town		
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e,	1 and Haalth am 27 other tr		20a. Method of Disposition	15/3011	20b. P	Placa of Dis	position (Ner	me of		Date	20c. Location		
no	permit. Pagas 1 and Department of Health Important: If Itsm 27 any injury or other trong.		1 ☐ Burial 2 【Cremation		.0		remetory or o			1 100 100		•	
altimore			4 ☐ Donation 5 ☐ Other (5	· · · · · · · · · · · · · · · · · · ·	Met	ropo	Litan (22. Name an		an of Facility				Virginia
Ва			Michael	QN I	Ira	14 1			1	Dr Gai			D. 20877
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o <	S 00 00	्र	examiner? 1 ☐ Yes 2 🔯 No	Hospitel: 1 ☐ Inpa	tient 2	ER/Outpat	ient 3□ DC	DA Oth	ner: 4 🖾 Nursing	Home 5 ☐ Res	idenca 8 🗆 Ott	ner (Specil	(y)
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ā		Certification:	3 Suicide 6 Could 4 Homicide determ	nined 200. Flace of I	Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)						(Street end Numi own, Stete)	ber or Rure	el Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Dir complataly filled In			ng Physician: To the bes									
	n 24 he Fi	edical	one) 2 Medical	Examiner: On the besis end menner s		tion and/or	investigation,	, in my c	opinion, death occ	curred at the time	, date and place,	and due to	o me cause(s)
	To the com	Σ	29b. Signature and title of	F)()			290	. Licens	se numbar		29d. Data signe	d (Month,	Dey, Year)
	10		-X(DISOTI)			7	579	2	April 2	2 1	997
,	, -	- 4	30. Name and address of person	who completed cause of	death (Item	1 23a) (Tyr	e, Print)				APLIL 2	.5, 1	,,,
		1			- tron	/(1)/-							

Swaroop G. Rao, M.D., 50 W. Edmonston Drive, # 504, Rockville, Maryland 20852-1228
31. Date filed (Month, Day, Year) 32. Registrar Signeture

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** May Month Day 199 Year Florence S. Rothwell 1 13:05 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Medpointe Elkton

If Under 24 Hrs. 8. Date of Birth
(Month, Dey, If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Deys 1 M 2 KF 221-03-0022 80 Yrs. Director Sept.2,1916 Delaware Usuel Residence of Decedent death with the Manyland 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health end Mental Hygiene.
Int: if item 27 is marked other than "natural", or items 23a or 28a-f show Jry or other traumatic event, the Med cal Examiner must be notified as 10d. Inside City Limits 1 Yes 2 No Director New Castle Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 North Brown Leaf, Rd. 19713 Completed by Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indian, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 217 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Executive Secretary Chemical 18. Mother's Name (First, Middle, Meiden Surneme) 17. Fether's Neme (First, Middle, Last) Be John Jacob Stengel Lydia Mote 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2: Department of Health er Important: if item 27 is any injury or other trau Joan R. Bader 1833 Glen Ridge Rd. Baltimore, Md. 20b. Pieca of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State 13 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Newark Cemetery 5-5-97 Newark, Delaware 4 ☐ Donetion 5 ☐ Other (Specify) 22 Name and Address of Fecility Robert T. Jones & Foard, Inc. 21. Signature of Funeral Service Licens 122 W. Main St., Newark, De. that caused the death. Do not enter the mode of dylng, such as cardiec or respiretory arrest, use on each line. Approximete Interval Betw Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or es e consequenca of) Examiner The law requires that the death certificete be executed the buriel-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or es e consequenca of) for use es Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? cate has been signed by , page 2 should be detec 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ Be Completed 24e. Wes an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of deeth? this certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No spital or Attending Physicien: The hours after death.
Ineral Director: After this certificate y lilled in by the funeral director, pa 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Menger of Death 28d. Describe how Injury occurred 28b. Time of 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 1 Naturei 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 6 To the Hospital within 24 hours a To the Funeral Completely lilled Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

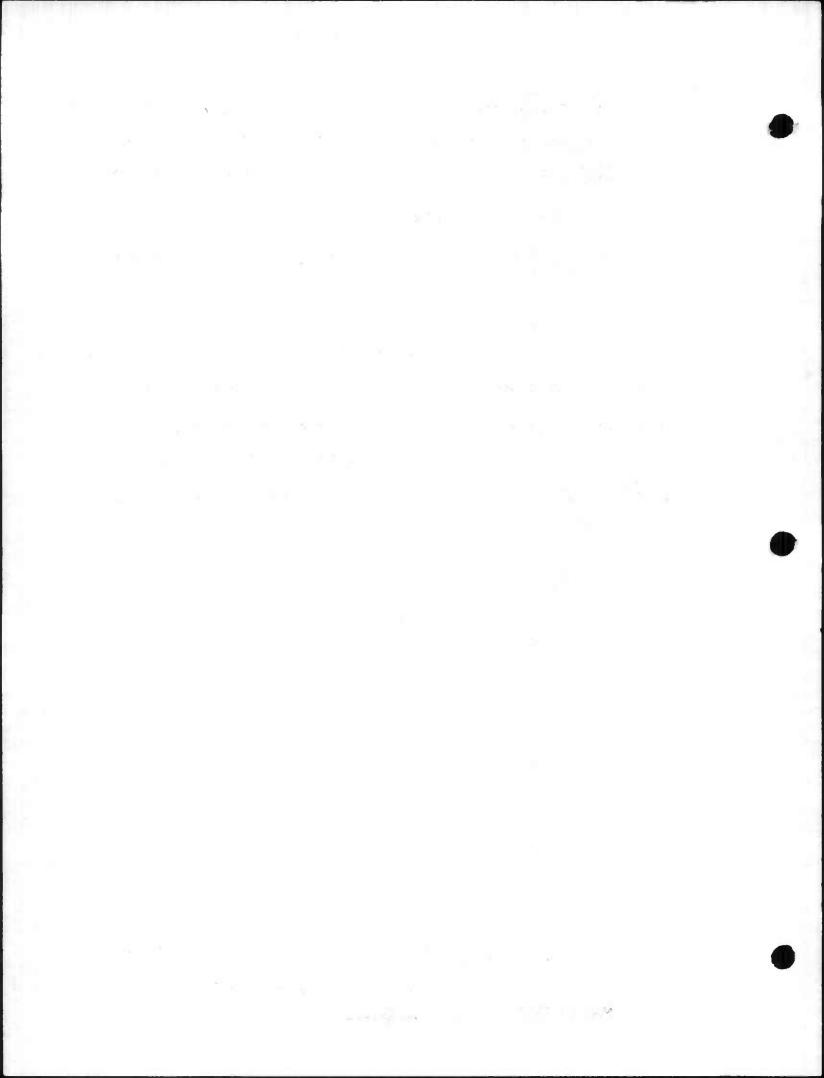
□ Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end manner steted. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Sachder, MD Ave, North East, MD 322 2190 Lecil 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State MAY 0 6 1997 Jula Davidson Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

14879

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	Physici /Medi		1. Decedent's Nam			son						Data of De Month	Day	Year	3. Time of Death 7:00 AM
	Examir		4a. Facility Name (0			4b. City, Tow		tion of Deat	h 4c. County		
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١	Funeral Director		5. Social Security N 218-09-	5169	6. Sax 1√2 M 2□ F		yrs. last birthda Yrs.	Months	1 Year Days		Min.	Date of Bir (Month, Da OVEM	y, Year)	9. Birth Cou 191	place (State or Foreign intry) 5 N • C •
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	death with the Meryland ms 23a or 28a-f show Lmust be notified at	Funeral Director	Md.		Cecil		E1ktc								10d. inside City Limits 1 ☐ Yas 2 X No
	また。 は と な る な	Sire	10e. Street and Nu	mber				10f. Zip	Code				10g. Citizen of	What Cou	intry?
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	sep	ne	11. Maritai Status		12. Was Da Armed F	cedant Evar	r in U,S. 13	. Was Deced	dant of	Hispanic Origi ban, Mexican,	in? (Speci	fy Yes or No			ican indian,
21215-0020	s 1 and 2 should be filled within 72 hours after death with the Menylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or itsma 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Marr 3 ☐ Widowed		led 1 TYYas	2 □ No Giva Dates: ₩₩				Specify:		and along	Specif		hite
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21	d 2 should be filed within thand Mental Hygiene. 7 is marked other than "traumatic event, the Mental than than than than than than than than	Completed	Elementery/Seco		1	(1-4or 5+)					or working				
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re,	t He man		20a. Mathod of Dis			2	20b. Place of Disi	osition (Nan	na of			Data	20c. Location		
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Baltimore,	nt. Pages 1 and autment of Health ortant: if Itam 27 injury or other tr		21. Signature of Fig.							ess of Facility					
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifiar (Check only one)	1 Certifying 2 Medicai E	g Physician; To th Examiner: On tha l and ma	e best of my basis of axa nnar stated.	y knowladga, daa mination and/or i	th occurred invastigation,	at the t	ime, deta and oplnion, daath	place, and	d dua to tha at tha tima,	causa(s) and m data and ptace,	anner as and dua	stated. to the causa(s)
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State of Maryland / Department of Health and Mental Hygiene 9 7

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	certricate be executed offing physician and use es the burlal-transit	Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		ſ	Due to (or es	e consequ	ence of):						1		
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Division of Vital Records,	or Attending after death. Director: After I in by the fune	cat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	-				М	10	Yes 2□						
\geq	red C	E	4 Homicide determ	ined 288. Pl	ece of Inju illding, etc.	ry - At home, . (Specify)	ferm, stre	et, fectory,	office		2	81. Location City or To	(Street and Nown, Stete)	umber or Ru	ural Route	Number,
		Certification:														
- 3	To the Hospital within 24 hours To the Funeral completely filled		29e. Certifier 1 Certifyli	g Physician: To	the best of	f my knowledg	ge, deeth	occurred e	the tin	ne, dete en	d pleca, e	nd due to the	e ceuse(s) end	I manner as	steted.	
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	of the company of the	ž	29b. Signature and title of	ir				29c.	Licens	e number			29d. Data si	gned (Mont	h, Day, Ye	ar)
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			U.S. SACHDEN	IND.				cule à	50,		K (0)	No M	0 49	4		
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	Registr	rar	MAY 0 1 19	9/	lie Das	4dson-1	maria	•								

WRC 97-2341-033

FRANCIS W.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Depa

rtment of Health and Mental H	ygiene	9.	7		1.	8	Ω
tificate of Death	Deg No	-	1	1	4	U	U

RILEY	JR.
- 1	Physician
	/Medical

Examine

3. Tima of Deeth 6:50 AM

10d. Inside City Limits

Black

Approximete Intarvel Batween Onset end Deeth

1 1 Yes 2 No

29d. Defa signed (Month, Dey, Yeer)

APRIL 30, 1997

1 Yes 2 No

Funeral

Director with the Maryland items 23a

Director

Funeral

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7 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examiner must be nothed at permit. Pages 1 and 2 should be filed within 72 hours efter death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 28a any injury or other traumatic avant

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Examiner physicien end s the buriel-transit The law requires that the death certificate be executed Physician/Medicai s been signed to should be det à Completed certificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, t Be Medical Certification: To An 24 hour.
The Funeral Dir.
To filled in

P.O. Box 68760

Records,

Division of Vital

Completed Be 3 Sulcide 4 Homicide 29a. Cartifiar (Check only one) 29b. Signeture end title of cartifiar

1. Decedent's Name (First, Middla, Last) 2. Data of Death Month Day Yaar FRANCIS W. RILEY, JR. APRIL 29, 1997 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth MORITZ DR. 6018 ST. TEMPLE HILLS Prince George's If Under 1 Yeer Months Days If Undar 24 Hrs. Hours Min. 5. Sociei Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (Steta or Foreign Country) 1 M 2 □ F Yrs. 577-80-0641 39 Jan. 11, 1958 Washington, D. C. Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location Maryland Prince George's Temple Hills 10e. Street end Numbar 10f. Zip Code 10g. Citizen of Whet Country? 6018 St. Moritz Drive 20748 United States Was Decedent of Hispenic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S, Armed Forces? 14. Race - Amarican Indian, Bleck, White, etc. 1 Nevar Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowad 4 ☐ Divorced 16e. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Driver Private 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meiden Sumema) Francis W. Riley, Sr. Mary J. McLaurin 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Addrass (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) 2606 Amy Lane, #3, Memphis, Tenn. <u>Mary Jane Riley - Mother</u> 38128 20b. Plece of Disposition (Nema of cemetery, cremetory or other pleca) 20e. Mathod of Disposition 20c. Location - City or Town, State Deta 1 Surlal 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 5/6/97 Landover, MD Harmony Memorial Park 21. Signeture of Funerei Service Licenses 22. Name end Address of Facility STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E., Washington, D.C. 1. Enter the disaase, or complications that causad the death. Do not entar the moda of dying, such es cardiac or respiretory errest, ock, or heart failure. List only one ceuse on each line. Immediata Ceuse (Finel Intra cranial Hemorrhage disease or condition resulting in deeth) Dua to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enfer Underlying Ceuse (Disaese or Injury thet initiated evants resulting In deeth) Last Dua to (or es e consequence of) Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 ≥ Yes 2 □ No 25. Was case referred to medical 26. Piece of Deeth (Check only ona) examiner / 1∕ Yes 2 No Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatianf 3 ☐ DOA 27. Manner of Deeth 28e. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturel 5 Panding 1 Tas 2 No investigation 2 Accidant 6 Could not be datarmined 28f. Location (Streat and Number or Rural Route Number, City or Town, Stefe) 28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

State Registrar Stephen S. Radentz 31. Dete filed (Month, Day, Yaar) 32. Reg MAY 02 1997

30. Nema end addrass of person who complated causa of daath (Itam 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 32. Registrer's Signeture

1 Cartifying Physician: To tha best of my knowledga, daeth occurred at tha time, data and plece, end due to tha causa(s) and menner as stated.

**Compledical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and menner stetad.

29c. Licensa number

O.C.M.E.

DHMH 16 Rev 6/95

1.00

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedent's Name (First, Middle, Last) 2. Data of Death **Physician** /ernee da APRIL 1997 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Undar 24 Hrs. If Under 1 Yaar 5. Social Security Number 6. Sax 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1□M 2√F 82 577-05-5070 Yrs. November 13, 1914 Mississippi Usual Residence of Decedent 10c. City, Town or Location Washington 10a. State 10b. County 10d. Inside City Limits D.C. Director XXYes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20011 U.S.A. 1212 Decatur Street, N.W. Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2√No Specify: Black by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Domestic 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Robert Johnson Seena Knight 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Mrs. Vernelle Carson (Daughter) 1212 Decatur Street, N.W. Washington, D.C. 20011 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burlal 2 ☑ Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. 4/29/97 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 21. Signality of Funeral Service Licenses 22. Name and Address of Facility Rollins Funeral HOme, Inc. 4339 Hunt Place, N.E. Washington, D.C. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death intracerebral hemorrhage 9 days Immediete Cause (Finel diseasa or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or es e consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably \$€Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Anpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not ba 28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner es steled. Medical 29a. Certifier Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Dey, Year)

State

To the Hospital inthin 24 hours a Hospital

Funeral

Director

28a-f show

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items 23a

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permit. Pegas 1 end 2 should be filled within 7, Department of Health end Mental Hygiane. Important: if item 27 is marked other than "na any injury or other traumatic event, me Media. panse.

Physician

/Medical

Examiner

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signed by the attanding physician d be detached for use as the buna

or Attending Physician: The lew requires that the death certificata be executed after death.

Director: After this certificata has been signed by the attending physician and

Box 68760.

Division of Vital Records, P.O.

traumatic event, the Medical Exarciner must be notified at

with the Maryland

filed within 72 hours after death

21215-0020

Baltimore, Maryland

DAV 1 D (31. Dete filed (Month, Dey, Yeer) APR 29 1997

32 Registrar's Signature

DHMH 16 Rev 6/95

30. Name end address of person who completed ceuse of deeth (Item 23a) (Pype, Print) ICROSS HOSPITAL SIVER SPRING MD

GARCIA

Registrar

filled in by the

A TO THE PARTY OF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First Middle Last) 2. Data of Daath 3. Tima of Death Month Yaar 11:20 AM 4a. Facility Nama (If not institution, giva straat and number) 4c. County of Death 4b. City, Town, or Location of Death Laurel Regional Hospital Laure1 Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | March | Pay, Year | March | 7, 1928 5. Social Sacurity Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 1□M 2KXF 69 Yrs. 228-32-2726 Nansemond County, Usuat Rasidance of Dacedant Virginia 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Prince George's Mary land Laure1 1 Yas 2 □ No 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda 20723 9536 Canterbury Riding U.S.A. 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yas 220No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarlcen Indian, Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify: 30 Widowad 4 □ Divorced Specify: Black. 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedent's Educetion (Spacify only highast greda complated) 16b. Kind of Businass/Industry Collega (1-4or 5+) Elamantary/Sacondery (0-12) Education Industry Teacher 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Essex Watson Lillie Holley 19a. Informent's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Coda) Mrs. Elaine Watson (Aunt) 1153 North Carrington Portsmouth, Virginia 23701 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 1XXBurial 2 ☐ Cramation 3 ☐ Ramoval from State Balm of Gilead Church Cemetery 5/1/97 Suffolk, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licenses 22. Nama and Addrass of Facility Applewhite Funeral Home 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. 2. Ha Immediata Causa (Finat diseasa or condition rasulting to deeth) 10 moult Dua to (or as a consaquance of): Sequantially list conditions, if eny, leeding to Immadiete ceusa. Entar Undarlying Causa (Disaasa or Injury that initiated avents Dua to (or as a consequence of): Due to (or as a consequence of): rasuiting In death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yas 2 1 No 1 Yas 2 No 25. Was cesa rafarred to medice! axaminar? 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 1 Yas 20 No 5 ☐ Rasidance 6 ☐ Othar (Specify)

/Medicai Examiner

Physician

Physician

/Medical

Examiner

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Director

28a-f show

Director

Funeral

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Completed

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7 is marked other than "natural", or itsms 23a or 28a-f shov treumstic event, the Modical Examiner must be notified at

"natural", or itsms 23a

permit. Pages 1 and 2 should be filed within 72 hours efter. Department of Health and Mantal Hygiana. Important: If Item 27 is merked other than "natural", or ites any injury or other treumatic event.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records,

the Maryland

Examiner Physician/Medical þ Completed Be Certification: To

the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed hes page certificate Aftar t or Attending after death.

Director: Aff 24 hours after Funerei Dire-letaly filled in b Hospitai pletaly f

Medical To the I within 2 To the F State Registrar

30. Nama and eddrass of person who complated ceuse of death (Itam 23a) (Type, Print)

5 Panding invastigation

6 Could not be datarmined

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28b. Tima of

29o Licansa number

2 No

28c. Injury at Work?

1 Yas

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

28d. Dascribe how injury occurred

31. Data fillad (Month, Day, Year)

29b. Signatura and titla of certifla

27. Manner of Death

1 ValNeturel

3 Suicida

29a. Certifiar

4 Homicide

(Check only one)

14800 32. Ragistrer's Signatura

DHMH 16 Rev 6/95

The Control of the Control

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 14884 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** Month EDITH VIRGINIA RAMEY APRIL 23, 1997 7:13AM /Medical 4a. Facility Neme (If not institution, give streat end number) 4b City Town or Location of Death 4c. County of Deeth Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON If Under 1 Year If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Securify Number 7. Age (In yrs. last birthday) Birthpieca (State or Foreign Country) **Funeral** Days Hours 1 □ M 2X F Director 230-18-3378 80 Yrs. AUG. 14,1916 BLAND, VA Usual Residence of Decedent 10e Stefe 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1X Yes 2 No PRINCE GEORGE'S LARGO 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Counfry? ŏ 20772 USA 500 N. HARRY S. TRUMAN DRIVE 23a Herra 2 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 X No Specify: Specify: WHITE þ XXWidowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Spacify only highest grede completed) permit. Pages 1 and 2 should be filed within:
Department of Health and Mental Hygiene.
Important: If Nem 27 Is marked other than any Injury or other traumatic Elementary/Secondary (0-12) College (1-4or 5+) PVT. HOUSEWIFE 8th 17. Fether's Nema (First, Middle, Last) 18. Mother's Name (First, Middla, Maldan Surneme) Be UNKNOWN DANIEL JACKSON 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) SHADYSIDE, MD ROBERT RAMEY/ SON 1309 AVALON BLVD. 20764 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremefion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 4-26-97 SUITLAND, MD CEDAR HILL CEMETERY 22. Name and Address of Fecility MARSHALL'S FUNERAL HOME 4308 SUITLAND RD. SUITLAND, MD 20746 23a. Pert1. Enfar the disease, or complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Betw Onset end Death **Physician** /Medical Immediete Ceuse (Final diseesa or condition resulting in death) Examiner Examiner attending physician end for use es the burial-transit The law requires that the death certificate be axecuted Sequentielly list conditions, if any, leading to Immediata cause. Enter Underlying Ceuse (Diseese or injury thef initieted events resulting in deeth) Lest Box 68760, Physician/Medical Due to (or as a consequence of): P.O. 1 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by page 2 should Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of causa of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital lal or Attending Physician: The sefer death.

No Director: After this certificated in by the funeral director, pa Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Death Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Panding investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homleide To the Hospital within 24 hours e Hospital edical McCertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end manner steted. 29e. Certifier completaly 29b. Signetura and fitte of certifier 29c. Licansa number 29d. Deta signed (Month, Dey, Yeer) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) RIVIES

MID

32, Registrar's Signature

State Registrar 31. Dete filed (Month, Day, Yeer)

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 4885 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deet) 1-15 A.M **Physician** fonth /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner HOLY CROSS HOSPITAL SPRING MONTGOMERY SILVER 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖔 F Deys NEW YORK Yrs. Director 83 10, 1914 057-10-4080 the Maryland 10a Stete 10h Counts 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 ☐ Yes 2 No MARYLAND MONTGOMERY SILVER SPRING 10e. Street end Numbe 10f. Zip Code 10g. Citizen of What Country? 20906 14508 HOMECREST ROAD #428 UNITED STATES Funerai 12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. "natural", or iten filed within 72 hours effer 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 21215-0020 1 ☐ Yes 2 X No Specify: Completed by Specify: WHITE 3 XWidowed 4 ☐ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) HOUSEWIFE OWN HOME marked other Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) Peges 1 and 2 should be fill iment of Health end Mental Hitam 27 is marked oth 18. Mother's Neme (First, Middle, Malden Surneme) Be WILLIAM RABINOWITZ BERTHA ALPERN traumatic 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) GEORGE SCHULMAN (SON) 1801 STONEGATE AVENUE - CROFTON, MARYLAND 21114 other 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete H & 1 Buriel 2 Cremetion 3 Removal from State Department of Important: If any injury or KING DAVID MEMORIAL GDN. 4/30/97 FALLS CHURCH, VIRGINIA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecilit DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 20852 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Betw end Deeth **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Physician/Medical Examiner The law requires that the death certificete be executed Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last the buriel-tran pue Records, P.O. Box 68760. use as Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ page 2 should Completed 24e. Wes en eutopsy performed? Were eutopsy findings evaileble prior to Deen completion of ceuse of deeth? has certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No of Vital Be 25. Wes cese referred to medical exeminer? 28. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpetlent 3 DOA this 27. Menner of Deeth Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred After Division Attending 1 Netural 5 Pending Investigation 1 ☐ Yes 2 ☐ No death the 1 2 Accident after death 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral Di 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end manner as steted.

| Madical Examinar: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. Medical 29a, Certifie completely (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 0 D38435 30. Name and eddress of person who completed cause of deth (Item 23e) (Type, Print) 20902 AARON E. KENIGSBERG, MD. - 10313 GEORGIA AVENUE, SUITE 307 - SILVER SPRING, MD.

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

SO YAM

32. Registrer's Signeture

guia Davidson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Neme (First, Middla, Last) 2. Deta of Death 3. Time of Deeth Dey APRIL 26, **ABRAHAM** SUSSMAN 1997 5:15 AM 4e. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY 8. Date of Birth (Month, Day, Year) MAY 10, I 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar if Under 24 Hrs. 9. Birthpieca (State or Foreign Deys 1₽M 2□F Hours 082-05-8955 86 1910 RUSSIA Usuei Rasidenca of Decedent 10a. Steta 10c. City, Town or Location 10b. County 10d. Inside City Limits MARYLAND MONTGOMERY 1 Yas 2 No ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6111 MONTROSE ROAD #710 20852 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yas 2 X No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16e. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 SALES/DRIVER BAKERY 17. Fethar's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Maldan Surname) SAMUEL SUSSMAN GOLDIE SCHWARTZ 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Numbar or Rural Route Number, City or Town, State, Zip Code) MARY SUSSMAN 6111 MONTROSE ROAD #710 - ROCKVILLE, MARYLAND 20852 (WIFE) 20b. Piece of Disposition (Name of cametery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Slata 1 XBuriei 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) JUDEAN MEMORIAL GARDENS 4/29/97 OLNEY, MARYLAND 21. Signalure of Funeral Service Licensee 22. Name end Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND 20852 23a. Pert1. Enter tha disaese, or complications that caused the death shock, or heert feiture. List only one ceuse on each line. Approximete interval Betwean Onsal and Death immediete Ceuse (Finei disaesa or condition resulting in daath) CEREBROVALWURR ACCIDENT KRART FAIWNE Dua to (or es e consequance of) Sequentially list conditions, if any, leeding to immediale cause. Enter Underlying Causa (Disaase or injury that initiated evants resulting in death) Lest MYPRRTRNSION Pert II. Other significant conditions contributing to death bul not resulting in the undariying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Wera autopsy findings evailable prior to completion of causa of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

by

Completed

7 is marked other than "natural", or itema 23e or 28a-f shor traumatic event, the Medical Examiner main to notified at

filed within 72 hours after Hygiene.

permit. Peges 1 and 2 should be file Deperment of Heelth and Mental Hy, Important: If Item 27 is merked othe any Injury or other traumatic event

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records,

Division of Vital

the Maryland

physician end s the buriel-transit thet the death certificeta be executed attending | 3 signed b peen pege 2 certificate

Examiner Physician/Medical þ Completed To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be Certification: To

24a. Was an autopsy performed? 1 Yes 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. injury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 3 Suicida 6 Could not be datarmined 28a. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 4 Homicida

29a. Certifier (Check only one)

edical

1 Cartifying Physician: To the best of my knowledge, daeth occurred at tha time, dete end placa, end dua to tha cause(s) end mennar es stated.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the tima, dete and place, end dua to tha causa(s) and manner stated.

29b. Signatura and litie of cest

29c. Licansa numbar

29d. Dala signed (Month, Day, Year)

1 ☐ Yas 2 ☐ No

D27427

APRIL 26, 1997

30. Name and addrass of pulson who complete cause of daeth (Itam 23a) (Type, Print)

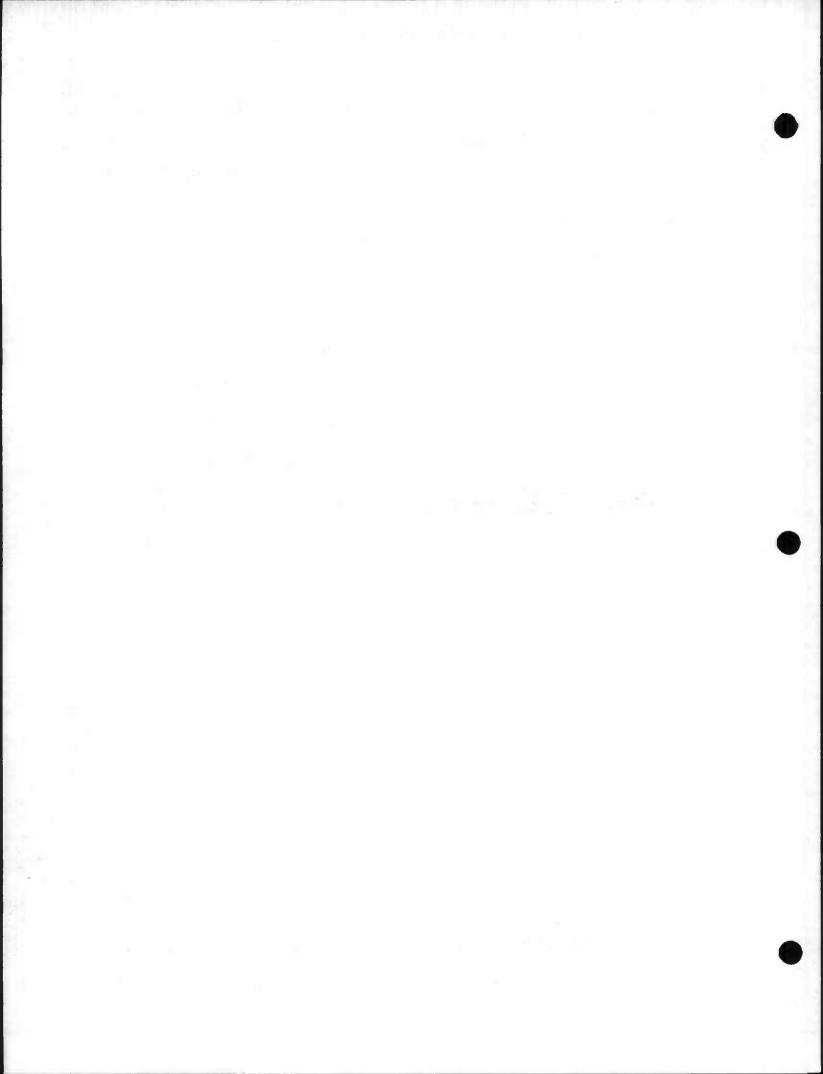
,7.0 9406 OLD GEORGETOWN ROAM, ARTHESOA, MOZOSIA YATA BAKSKI

State Registrar

32. Registrar's Signature

Suna Dandson-Randson 31. Dete filed (Month, Day, Year) APR 28

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				State of Ma	aryiar		rtificate of	Death	Mental Hy	Reg. No.	97	14887
	Physic /Medi		Dacadent's Name (First, Middle, Lo Richard Harding						2. Date of D Month April	Day 24, 199	Year	3. Time of Deeth 2:45PM
	Exami		4a. Facility Name (If not institution, gir					4b. City, Town, or			ly of Death	2.45111
	Funeral Director		578-62-2907			last birthday) Yrs.	If Under 1 Yaar Months Days		8. Date of B	irth lay, Year)	9. Birthp Coun Wash	cy place (State or Foreign stry) nington, DC
	pue *		Usual Residence of Decedent 10a. Stete 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Aaryl f sho	0	Maryland Montgon	10 7 37								1 ☐ Yes 2 ☐ No
	288-	Director	10e. Street and Number	icly	Une	vy Cha	10f. Zip Code			10g. Citizen of	What Cour	
	With Ba or		8101 Connecticut	- Avenue d	e 600 N	ī	20815					
	Jeath Tre 2	Funeral	11. Marital Status	12. Was Decedent				Hispanic Orlgin? (S	Specify Yes or N	United	State	
020	n 72 hours after death with the Maryland "natural", or frams 23a or 28a-f show odical Examinet must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorcad	Armed Forces? 1 Yes 2 1 If Yas, Give Year or Dates:	o Wor	1d '	f Yas, specify Cut 1 □ Yes 2 ☐ No	oan, Mexican, Puar	to Ricen, efc.)		ack, White,	etc.
5-0	72 ho	ted	15. Decedent's E (Specify only highest gro	ducation		18a. Deced	dent's Usual Occu	pation during most of wo	rt in a	16b. Kind of I	Business/Ind	dustry
Maryland 21215-0020	within jene. r than "	Completed	Elementery/Secondary (0-12)	College (1-4or 5 5+	+)	lite. L	sician	adning most of wo	rking	Genera	al Med	
pu	be filed tal Hygid other	Be	17. Fathar's Name (First, Middla, Last	")				18. Mothar's Na	me (First, Middle	e, Maiden Sume	m <i>e)</i>	
yla	should be nd Mental marked o	2	Richard Lee Spin	re				Anna Lo	uise Ha	rding		
Jar	2 should be n end Menta is marked raumatic ev		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ig Address (Stree	t end Number or Ri	ural Route Numi	ber, City or Town	n, Stete, Zip	Code)
Baltimore, I	permit. Peges 1 end 2 should be filed Department of Health end Mental Hyg Important: if Item 27 is marked other eny Injury or other traumatic event,		Michael W. Spire/ 20a. Mathod of Disposition 1□Burlel 2 【Cremation 3□	Removal from State	20b. P	lace of Dieno	cition (Name of	ont Aven	Data	timore, 20c. Location		Land 21231 wn, State
E	rtme rtant		4 Donation 5 Other (Special Structure of Funeral Service Lice	-	Mor			orium, I		Bethes		
Ba	permit. Pege Department of Important: if eny Injury or		Mail E.	lessey.	MOC	Be	thesda-(chevy Cha Maryland	se. Inc	. 7557	Wisco	neral Home/ onsin Ave.
	Physician /Medical Examiner		Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Chronic	obs		ve Pulmo	onary Dis		errest,	-	Approximate Intervel Between Onset and Death
	D #	Iner		Tobacco	Smo	king						
	ecute and -trans	Examiner	Sequentially list conditions,	U		r es e conseq	uence of):					
50,	Sien c		Sequantially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury	6								
ox 68760,	leath certificate be executed ettending physicien end I for use es the bunel-transit	VMedicai	that initiated events resulting in deeth) Last	d	Dua to (or	as a consequ	uence of):					
Вох	death cert	ciar	Part # Other elections and Mana									
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Vital Records	v requir been s should	Completed t	Upper Gastrointes	stinal Blee	eding	3				s an autopsy ormed?	ave	ere autopsy findings ellable prior to mpletion of cause death?
ž		Com	Pathologic Fractu	ire of a Do	rsal	Verte	brate		10	Yas 2□No	10	Yas 2∏ No
/ita	certificate	Be	25. Was case referred to medical examiner?					26. Placa of Dea	ath (Check only	one)		
5	Physic this c	2	examiner? 1 2 Yes 2 No	Hospital: 1 Inpatia		ER/Outpatlent	3LI DUA		lome 5X Res	Idence 6 □Ot	her (Specify	1)
Division of	After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Invastigation		Year)	28b. Time of Injury	M 1□	ryat rk? Yas 2□No	28d. Describe	how Injury occu	rred	
Ž O	X25 c	-	3 ☐ Sulcide 6 ☐ Could not be determined		ry - At ho . (Specify	me, farm, stre	eet, factory, offica			(Street end Num wn, Steta)	ber or Rure.	l Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled it	edical	29a. Certifier (Check only one) Cartifying Ph 2 Medicat Exam	ysician: To the best on niner: On the basis of and manner ste	examinet	vledge, deeth ion end/or Inv	occurred at the tilestigation, in my o	me, dete and placa opinion, death occu	, and due to the rred at the time,	cause(s) end m date and place,	anner as st and due to	ated. the cause(s)
	To the	29b. Signature and title of cartifier 29c. Licensa number							29d. Dafa signe	ed (Month, I	Dey, Year)	
	12+	,	20 Name and address 1	loung	M	A.	8112	2		April	25, 19	997
			30. Name end address of person who David V. Young, N				rint) it Avenue	a. N W	#104			
	Sta	e	31. Date filed (Month, Dey, Year)			ure Mark		- 9 41 0 77 0	, 104			
	Registr		APR 2 8 100	7 de la	houds.	10 mg	.00					

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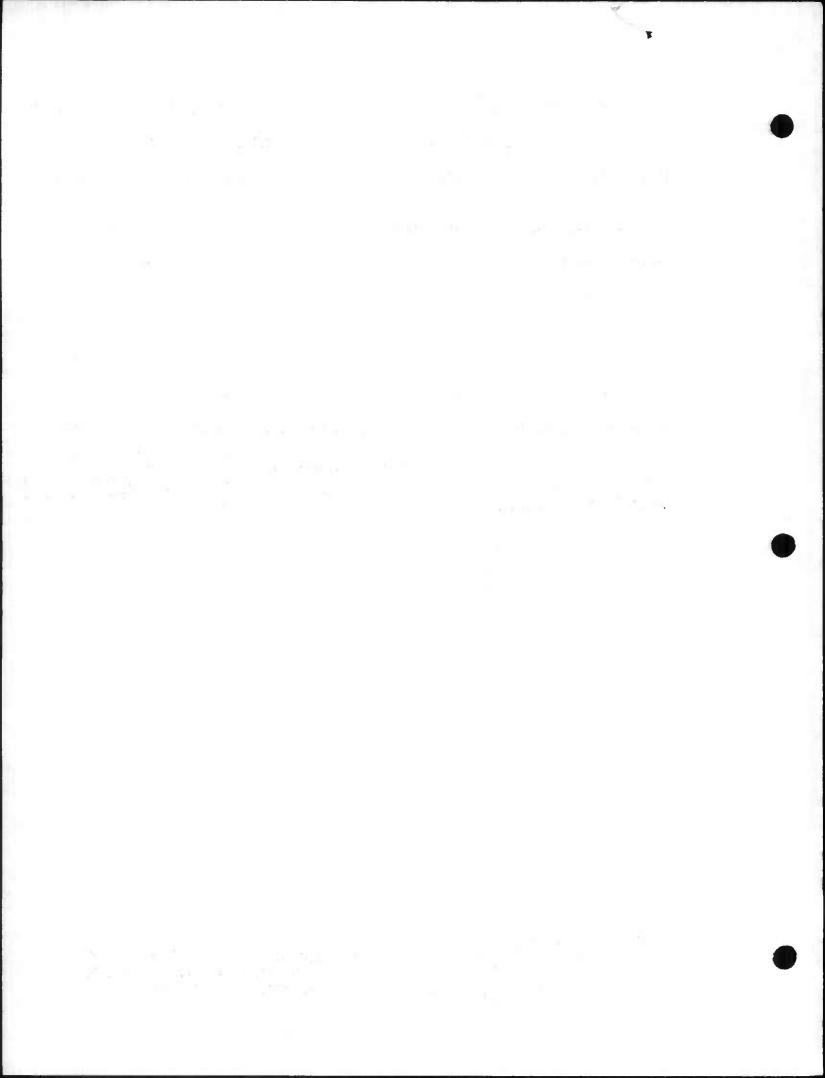
APR 23 1997 Community Co		State of Maryland / Department Certificate	of Death	giene 97 4888
48. CRy, Town, or Location of Death ANT INDAT ANALY AND HIGH CALL CENTER NATIONAL NAVAL NEDICAL CENTER NATIONAL NAVAL NEDICAL CENTER NATIONAL NAVAL NEDICAL CENTER NOTH BETTHESDAY NOTH BETT		nysician VICTOR SHVEDOFF	Month	
135-12-800 10 March 10 March		xaminer 4a. Facility Neme (If not Institution, give street and number)	The party of the party of the	4c. County of Death MONTGOMERY
The company of the		135-12-8001 1 M 2 □ F 78 Yrs. Months	Days Hours Min. (Month, Da	th ly, Year) 9. Birthplaca (State or Foreign Country) 16, 1919 Pennsylvania
Elementary/Secondary (o.12) College (1-4or 5-) Purchasing Agent Communi	with the Maryland a or 28a-f ahow be northed at			10d. Inside City Limits 1 \ Yes 2 \ No 10g. Citizen of Whet Country?
Elementary/Secondary (o.12) College (1-4or 5-) Purchasing Agent Communi	nours after death ural', or items 23 Learning mus	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wes Decedent Forces? 1 Never Merried 2 Married 1 Mercon World 1 Mercon	ent of Hispanic Origin? (Specify Yes or No- ify Cuban, Mexican, Puerto Rican, etc.)	
A Donesion S Other (Specify) North Hardyston Cemetery New J	ed within 72 h ygiene. or than "natu f, the Mexica	15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Purchasing	k done during most of working e retired) B Agent	16b. Kind of Business/Industry Communications
A Donesion S Other (Specify) North Hardyston Cemetery New J	and Mental H marked oth umatic aven	17. Fether's Neme (First, Middla, Last) Continue Incompanies Inc	Anna (not ava	ailable)
Physician / Medical Examiner Physic	Pages 1 and 2 ment of Health a ant: If Item 27 is jury or other tra	Ruth A. Shvedoff/wife 20a. Method of Disposition 11D Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) Ruth A. Shvedoff/wife 5 Waycros 20b. Place of Disposition (Nam cemetery, crematory or or or or or or or or or or or or or	pe of her place) April 30, 1997 on Cemetery	20c. Location - City or Town, State Hardyston Township, New Jersey
Physician Medical Examiner Medical Examiner	Depart Import any In	M00803 Betheso	la-Chevy Chase, Inc. la. Maryland 20814-	7557 Wisconsin Ave.
MYELOFIBROSIS Due to (or as a consequence of): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury the Initiated events resulting in death) Last Due to (or as a consequence of):	/Medical	cian dical Immediate Cause (Finel disease or condition resulting in death) SEPSIS		Onset and Death days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributions to death but not resulting in the underlying cause given in Part I. 1	be executed clan and curial-transit	MVFLOFTBROSTS		years
The state of the s	2 2 9 0	9 0		
24a. Was an eutopsy performed? 24a. Was an eutopsy performed? 24b. Yes 2 No 25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 28d. Describe how injury occurred injury 28d. Describe h	that tha cond by the detached	Tank II. Other significant conditions contributing to death but not resulting in the underlying of		tobacco use contribute to the cause of death? Yee 2□ No 3□ Probably 4☑ Unknown
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To be a subject to the subject to th	hysician: The certificate and director, part of the Co	25. Was case referred to medical examiner? 1 Yes 24 No Hospital: Yes Inpatient 2 ER/Outpatient 3 DO	26. Place of Death (Check only of Other)	one)
building, etc. (Specify)	or Attending fiter death. Nirector: After In by the fune rtification	1 Natural 5 Pending Investigation 2 Accident Squared Foundation 1 Square	1 ☐ Yes 2 ☐ No office 28f. Location (5	Street and Number or Rural Route Number,
29a. Certifier (Check only one) 29a. Certifier (Check only one)	he Hospita in 24 hours he Funeral pletely fille	29a. Certifier (Check only one) 29a. Certifying Phyelcien: To the best of my knowledge, deeth occurred to the control of the deeth occurred to the deeth		
29b. Signature and title of certifier 29c. License number 29d. Date signed (M 0101-051231 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CE	2041	1 + 1g. Danime de Terrey 10 01	01-051231 (VA)	29d. Date signed (Month, Day, Year) 04 / 25 / 97.

State Registrar

31. Date filed (Month, Day, Year) APR 28 1997

DOMINIC deKERATRY, LT, MC, USN 32. Registrar's Signeture

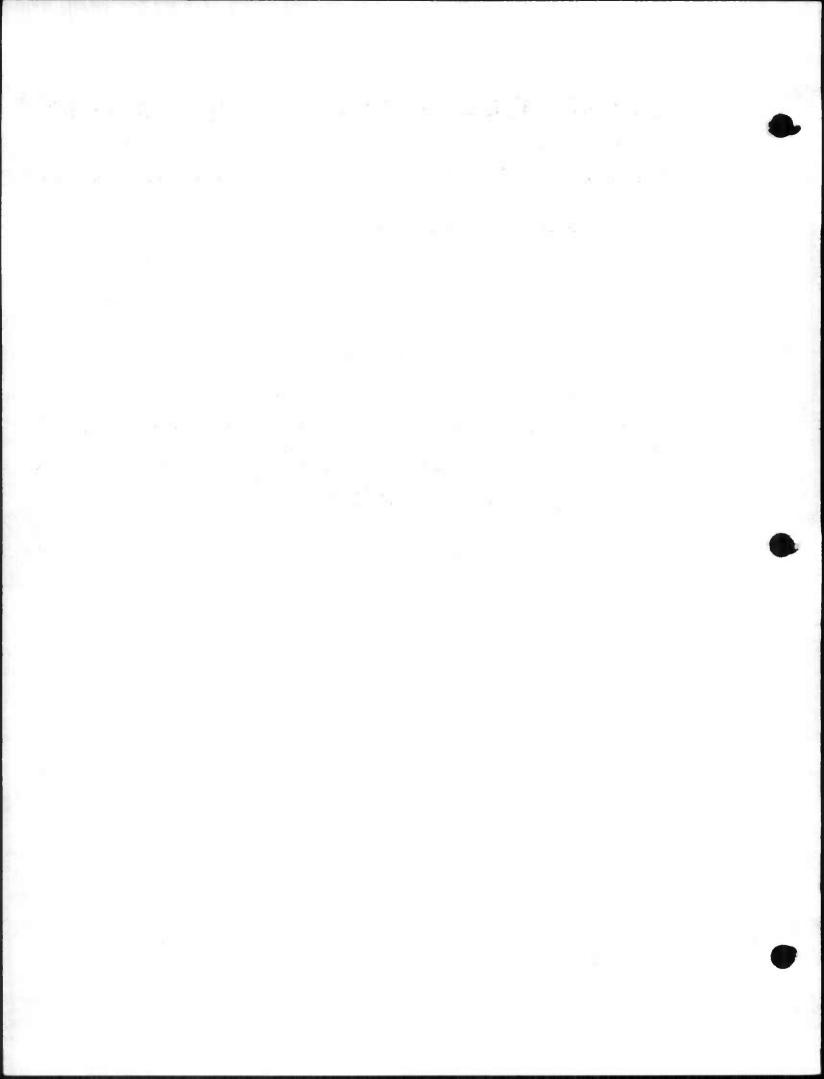
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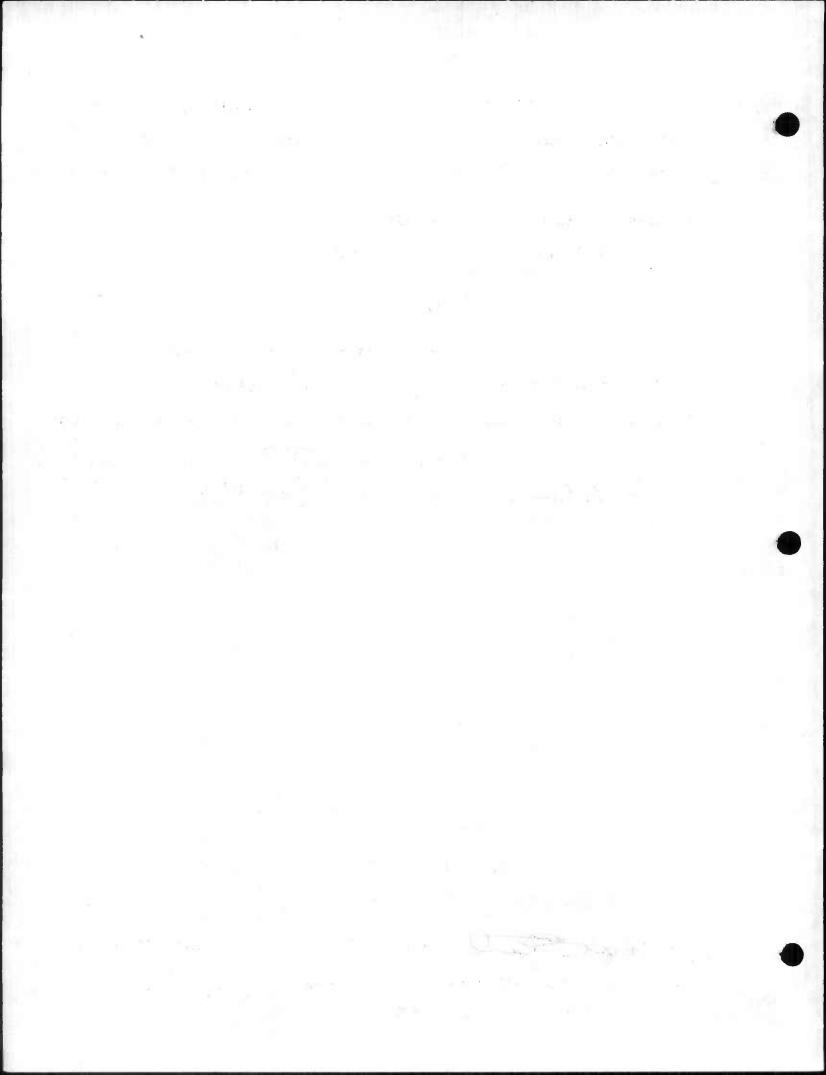
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/Medic	al	4a. Facility Nama (If not institution, giva street and num.		3 3	>CO 1	4b. City, Town, or Loca	ition of Death	4c. County	of Death	-
Examin	er	Holy Cross Hospital				Silver Spr	ing		omery	
Funeral Director	H	5. Social Security Number 6. Sax 1	. Aga (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Y	par)	9. Birthpiaca (St. Country) Pennsylv	ata or Foraign
-		Usual Rasidance of Decedent					NOV. 1/,	1910		
with the Maryland a or 28a-f show be notified at	or	10a. Steta 10b. County		Town or Loca						de City Limits Yes 2 No
the Mary 28a-f shu notified a	Director	Maryland Frederick 10e. Street end Number	New	Marke	10f. Zip Code		10g	Citizan of V	Vhat Country?	-
91 with 23a or		10308 Fox Chase Circle			21774		Un	ited S	tates	
er dea Nems	Funeral	11. Maritel Status 12. Wes Deced	lent Ever in U,S.	13. W	es Decedent of H Yes, specify Cubi	Ilspanic Orlgin? (Speci an, Maxican, Puerto Ri	fy Yes or No- can, etc.)		e - American India k, Whita, atc.	n,
	by Fu	1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 If Yes, Give Yaar or Dat	No les:		Yas 2 No	Specify:		Specify		
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farylan 2 should be 1 and Mental is merked o		19a. Informant's Neme/Ralationship (Type, Print)		19b. Mailing	Address (Street	and Number or Rural I		ity or Town,	Stata, Zip Coda)	
20 50 50 50		Clarence Norman Scott, J	r./son	3681	Mar-Lu F	Ridge, Jeff	erson,			
nor of or of		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from St				ce)April 27,			City or Town, Stat	
Baltimore, semil. Pages 1 at Department of Hea mportant: if Item 2 my Injury or other ands.		4 Donation 5 Other (Specify)	Parl		Memorial	l Park ss of Fecility Robe			le, Mary	
Balt permit Depart Import any inj		Maril E Cerre	4 M0080	Ro Ro	ckville,	Inc. 300 Maryland) West Me 20850-2	ontgom 805	nery Aven	ue
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Examiner		disaasa or condition rasulting in death)	Due to (or a	as e consequ	ance of):	any vase	man u	LAKEK	e gra	Na
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Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be control or the funeral director, page 2 should be control.	Completed	U					24a. Was en a periorme	utopsy d?	24b. Were auto available p completion	rior to
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Attending the formal of the fo	ficat	2 Accident invastigation 3 Suicida 6 Could not be detarmined 28a. Piece of detarmined	f injury - At hom	a, farm, stree	et, fectory, offica	Yas 2 No 28	f. Location (Stree	et and Numb	er or Rural Routa	Number,
Div	Certification:	4 ☐ Homicide detarmined building	, atc. (Specify)		. West 1890		City or Town, S	Stata)		200
	edicai	29a. Cartifiar (Check only one) Certifying Physician: To tha be a Medical Examiner: On the bas and manna	is of axamination	edga, daath o n and/or inve	occurrad at tha tirestigetion, in my o	na, data end place, an pinion, death occurred	d dua to tha caus at tha tima, data	e(s) and me and place,	onnar as stated. and dua to tha cau	ise(s)
To th Withir Comp	Me	29b. Signature and title of certifler	W 60		29c. Licans		29d	Date signer	Month, Day, Ye	ar)
6	-	Jame 19th	MN		D340	034		4/25/	97	
		Name and addrass of person who complated cause R	700 FA	RAG	UT AVI	e Kansii	VSTON	MD	20895	,
Stat Registra		APR 2 8 1997	gistrar's Signatur	n-Mande	D.					

DHMH 16 Rav 6/95



Physic		Decedent's Nama (First, Middle				tificate	e of L	Death	2. Date of D	Reg. No.	91	3. Time of Dee
Physic /Medi	cal	4e. Facility Name (If not institution		Savanna	ıh		4	h City Town o	April or Location of Dea	T .	97	6:05 AM
Exami	ner	1401 Langbrook		illiber)				Rockv			tgomer	у
uneral lirector		5. Social Security Numbar 212-64-4606	6. Sax 1⊠ M 2□ F	7. Age (In yrs 42	lest birthday) Yrs.	If Under Months	1 Year Days	if Undar 24 H Hours Mi	8. Date of B (Month, D Oct. 1	irth ley, Year) 9, 1954	9. Birthp Coun Wash:	lace (State or For try) ington,
ž		Usuel Residence of Decedent 10a. Stata 10b. County		10c. C	ity, Town or Lo	cation				_	11	0d. inside City Lir
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or 28	Sirec	10e. Street and Number				10f. Zip				10g. Citizen	of What Coun	try?
23a	rai	1401 Langbrook				2	0851			United	State	S
"naturel", or flame 23a or 28a-f show solical Examiner must be nutfied at	by Funeral Directo	11. Marital Status 1 □ Never Married 2 ☒ Marri 3 □ Widowed 4 □ Divorced	Armed F	2 No ve 197	If	Vas Deced Yes, spec	ify Cubai	spanic Origin? n, Mexican, Pue Specify:	(Specify Yas or N into Rican, etc.)	E	Raca - Amaric Bleck, White, city: Wh	
	Completed by	15. Decadent (Specify only highes	s Education	edu	16a. Deced	ent's Usua kind of won	l Occupa	ation furing most of w	orkina	16b. Kind o	Business/inc	dustry
	шb	Elementary/Secondery (0-12)	College (1-4or 5+)	life. E	OO NOT us	e retired,)		II. C	0	
1 5 E		17. Fathar's Name (First, Middla, I	ast)		Kelli	gerat	TOIL	Mechani	eme <i>(First, Middl</i> e		Govern	ment
D >	To Be	William Joseph							Umphlet	o, maiden our	9611107	
7 is marked of traumatic eve	-	19a. Informant's Name/Ralationsh	ip (Type, Print)		19b. Mailin	g Addrass	(Street e	end Number or i	Rure / Route Num	ber, City or Tox	vn, Stete, Zip	Code)
om 27 i other tra		Christine A. Sav	/annah/Wi	fe	1401	Langb	rook	Place,	Rockvil	lle, Ma	ryland	20851
		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 □Removal from	20b.	Place of Dispos cemetery, crem	sition (Nem netory or of	e of ther plec	April 2	6, 1997	20c. Location	on - City or To	wn, State
tant		4 □ Donation 5 □ Other (Sp	ecify)	Gat	e of He	eaven	Cem	etery				g,Maryla
important: If if any injury or once.		21. Signature of Funeral Service L	out	M001	.98 R81	Name and Dert 00 We	AAddres St M 11e,	umphirey ontgome Maryla	Funeral ry Avenu nd 2085	Home/ 1e 50-2805	Rockvi	lle, Inc
rsician ledical aminer	her	Immediate Cause (Final disaasa or condition resulting In death)	a. Me		c Lung		er					Onsat and Death
physicien end s the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury	b	Due to (or as a consequ	uence of):					1	
attending physicial for use es the bu	/Medical	Cause (Diseasa or Injury that Initiated events resulting In death) Last	c	Due to (d	or as a consequ	ience of):						
d for u	iciar	Part II. Other significant condition	e contributing to d	eath but not res	culting in the un	dorlylog og	use cha	on In Part I	22h Dio	I tobacco use	contribute to	the causs of dea
ed by the detached	by Physician/M	Take the significant contents	a contributing to a	batti bat not ioc	outing in the dir	delly lig Ca	iuse give	ni ili Farti.				ably 4 Unkr
5.8	Completed									s an eutopsy formed?	BVB	ere autopsy findin allabie prior to mplation of causa death?
as been sign 2 should be									1□	Yes 2 No	1	Yes 21X No
ate has been signi page 2 should be		25. Was case referred to medical examiner?	Hospital:		lenzo a silvari	• C 50	Othe	LP*	eath (Check only			
certificate has been sign irector, page 2 should be	<u>m</u>		1 TOOPITON .		ER/Outpatient 28b. Tima of		Bc. Injury Work	4 🗆 Nursing	Home 5 ☑ Ras 28d. Describe	how injury occ		"
this certificate has been signi al director, page 2 should be	2	1 ☐ Yes 2 ☒ No 27. Menner of Death	28a. Date	of Injury								
After this certificate has been signi funeral director, page 2 should be	2	1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending 2 Accident investigi 3 Suicida 6 Could no	28a. Date (Mon	th, Dey Year) of Injury - At h	Injury ome, ferm, stre	М		′es 2□No	28f. Location	(Straet end Nu	mber or Rure	l Route Number,
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irrector : After this certificate has been sign in by the funeral director, page 2 should be	Certification: To	1 Yes 2 No 27. Menner of Death 1 Natural 2 Accident 3 Suicida 4 Homicide 29e. Certifier 1 Certifying	28a. Date (Mon at be led 28e. Place buildi	th, Day Year) of Injury - At h ng, etc. (Special best of my kno	Injury ome, ferm, stre	et, factory,	office	e, date and pled	City or To	own, Stete)	manner as st	ated.
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To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Medical Certification: To	1 Yes 2 No 27. Menner of Death 1 Natural 2 Accident 3 Suicida 4 Homicide 29e. Certifier (Check only one) 1 No 1 Certifying 2 Madical E	28a. Date (Mon at be led 28e. Place buildi	of Injury - At h ng, etc. (Special best of my kno	Injury ome, ferm, stre	M et, factory, occurred e astigation, i	office t the time in my op	e, date and ples inion, death occ number	City or To	e cause(s) and date and place	manner as str e, and due to ned (Month, L	nted. tha causa(s) Dey, Year)
To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Medical Certification: To	1 Yes 2 No 27. Menner of Death 1 Natural 2 Accident 3 Suicida 4 Homicide 29e. Certifier (Check only one) 1 No 1 Certifying 2 Madical E	28a. Date (Mon 28e. Place buildi Physician: To the xaminer: On the band man	of Injury - At h ng, etc. (Specil best of my kno asis of examina ner stated.	Injury ome, ferm, stre owledge, deeth tion and/or invi	M et, factory,	office t the time in my op	e, date and ples inion, death occ number	City or To	cause(s) and date and place	manner as str e, and due to ned (Month, L	nted. tha causa(s) Dey, Year)

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Skinner CELESTIA JANE april 0755 21 1997 4a. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL Rockville Montgomery If Undar 1 Year Months Days If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) 1 ☐ M 2 🖾 F 577-09-7169 98 29, 1899 Washington, DC Jan. Usual Rasidance of Dacedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYas 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 211 Russell Avenue #725 20877 United States 14. Race - American Indien, Bleck, Whita, atc. 12. Wes Decedant Evar In U,S. Armed Forces? 13. Wes Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Maxican, Puarto Rican, atc.) 11. Maritel Status 1 ☐ Yas 2 █ No if Yas, Giva Year or Datas: 1 Naver Merried 2 Married 1 Yas 2XX No Specify. 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Spacify only highest grada completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Own Home Housewife 12 17. Fether's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumame) Martha Ann Middleton George E. Souders 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 403 Russell Avenue #201, Gaithersburg, MD 20877 Innis R. Skinner, Jr. (Son) 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 4/24/97 4 Donation 5 Othar (Spacify) Ft. Lincoln Cemetery Brentwood, Maryland 21. Signatura of Funaral Sarvica Licenses 22. Nama and Addrass of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 uchay 23a. Pert1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedieta Ceusa (Final disaasa or condition rasulting in daath) Dua to (or as a consaquance of) 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy onemia 1 Yas 2 1 No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarrad to madicel axaminar? 26. Placa of Daath (Check only ona) Hospital:

Physician /Medicai Examiner

physician end the burial-tran

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ate nas been signed by page 2 should be detect

funeral director,

completely filled in by

Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifica

To the Hospital of within 24 hours e To the Funeral D

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Completed

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Certification:

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the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

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Funeral

Director

Item 27 is marked other than "natural", or Itema 23a or 28a-1 show other traumatic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Health end Mental Hygiene. Important: if them 27 is marked other than "natural", or frems 23s any Injury or other traumatic event, the Modical Examiner must obtice.

Baltimore, Maryland 21215-0020

the Marylend

with

Examiner Sequentially list conditions, if eny, laading to immadiata causa. Enter Underlying Cause (Disaasa or injury that initiated evants rasulting in daath) Last Physician/Medical

4 Homicida

29a. Cartifiar

Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 28d. Dascribe how injury occurred

1. Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accident 6 Could not be datarmined 3 Suicide

MO

28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 14 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

(Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. 29b. Signetura and Mill of certifiar

29c. Licansa number 023911 29d. Date signed (Month, Day, Year)

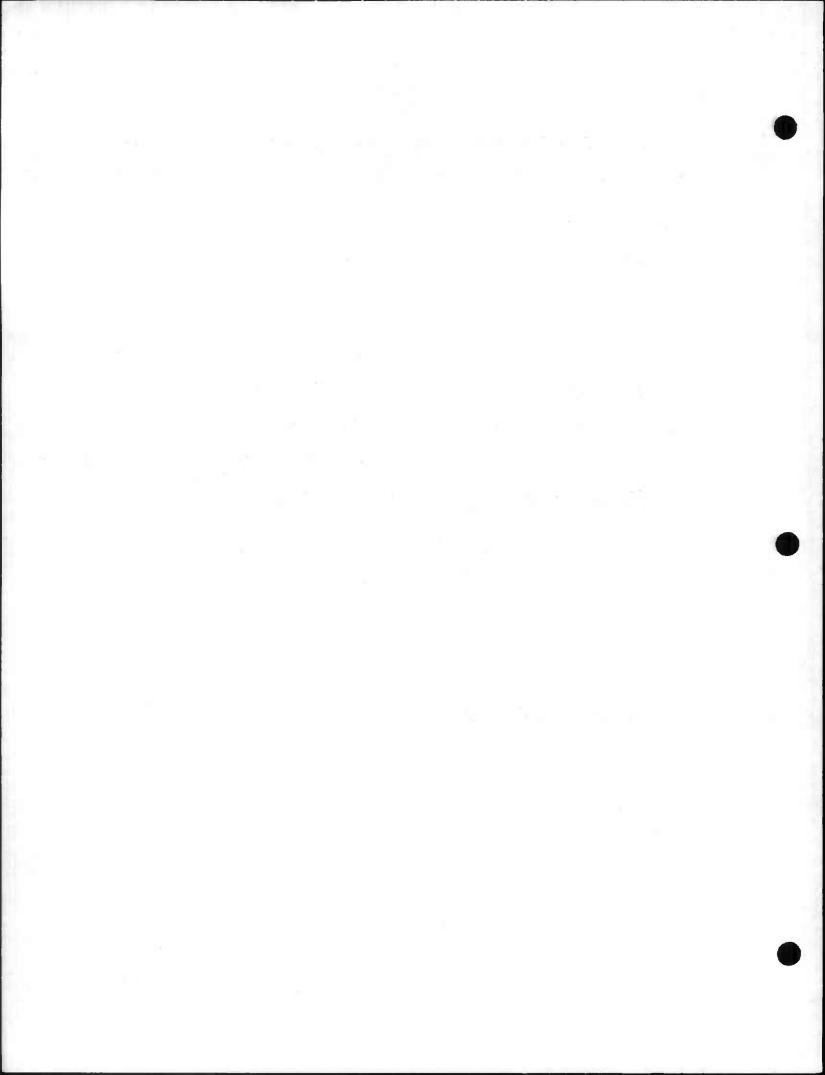
30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print)

9410

old Georgetown ad.

Bethesda Md. 20814

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 28 WILLIAM STROHMAIER 1997 Dril /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Union Hospital of Cecil County E1kton If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Cecil If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys 1⊠M 2□ F Months Yrs Director 222-20-3285 November 15, 1931 Delaware Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Medical Examinar must be notified as 1 ☐ Yes 2 ☑ No Director Rising Sun Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 807 England Creamery Road Funeral 21911 United States 12. Was Decedent Ever In U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give US Army Year or Dates: 1951-53 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Peges 1 end 2 should be filed within: Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "r any fijury or other traumatic event, are Med Optice. Eiamentary/Secondary (0-12) College (1-4or 5+) 12 Self-employed dairy farmer dairy farm 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Be Gottlieb Strohmaier Anna Eisenman 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Code) Doris D. Strohmaier / Spouse 807 England Creamery Road, Rising Sun, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cramatory or other place) Data May 2 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) Gracelawn Memorial Park 1997 New Castle, Delaware Funeral Service Cices 22. Neme and Address of Facility Crouch Funeral Home 127 South Main Street, North East Md 23a. Part1. Enter tha disease, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immadiate Cause (Final disease or condition resulting in death) Cardiac Arrest Due to (or as a consequence of): PRIMARY GLIONA BRAIN OF the buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Dua to (or as a consequence of) ettending physiclan for use es the burie Physician/Medical Due to (or as a consequance of): signed by the 4 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Wara autopsy findings available prior to 24a. Was an autopsy completion of cause of death? page 2

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0020

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Records,

Division of Vital

the Hospital or Attending Physician:

certificate

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Director: Aft
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To the Hospital
within 24 hours a
To the Funeral C filled

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Certification:

Medical

1 Yas 2 No 1 ☐ Yes 2 ☐ No

25. Wes cese referred to medical 1 Yes 2 No 27. Manner of Death 28e. Date of Injury (Month, Day Yaar)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

26. Place of Death (Check only one)

5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be datarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide

28f. Location (Straat and Number or Rural Route Number, City or Town, State)

29b. Signature end title of certifier

1 Natural

29a. Certifian

156 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Jones K. Deanwill my

C10000375

4/30/97

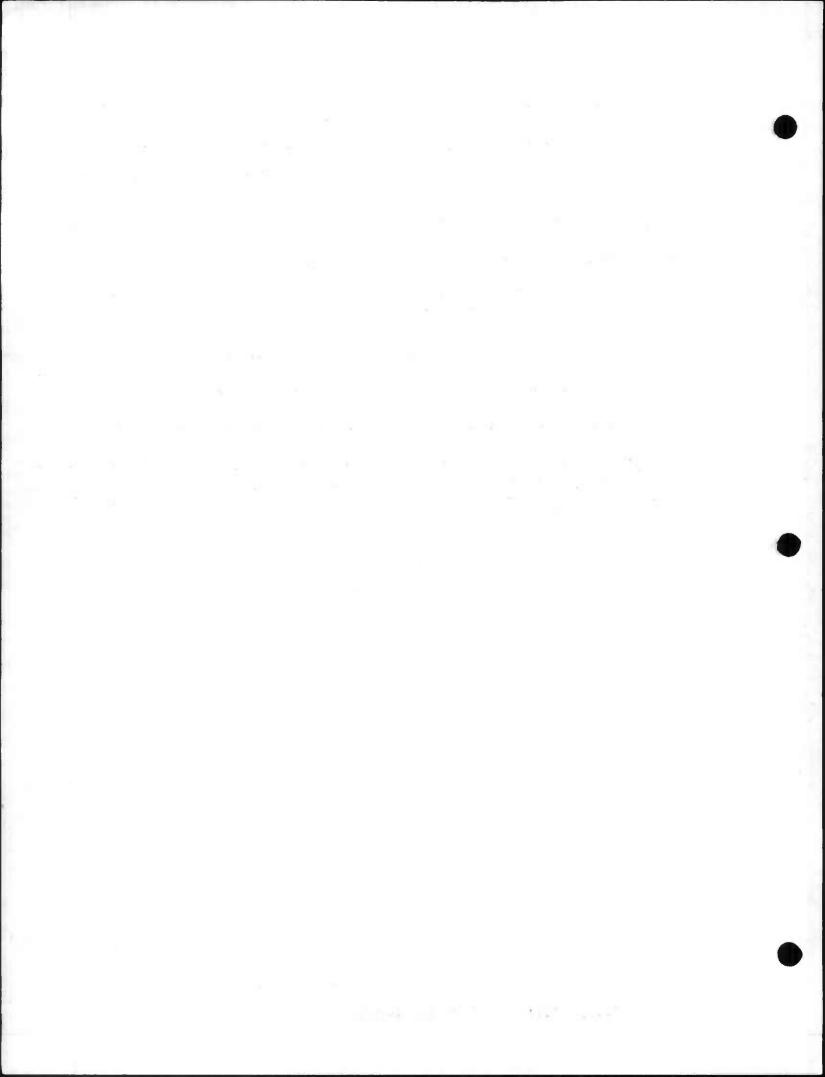
30. Nama and address of person who complated causa of death (Item 23a) (Type, Print)

James R. Deerwood, we 167 W. HRIWST. Nework, Del. 19711

Registrar

31. Date filed (Month, Day, Year) APR 3 0 1997





Item 23,27 per MEO Film G747 5-21-97 rja

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

ysician	ľ	. Decedent's Nem	e (First, Middl	e, Last) CHARLE	S		S	ноок			2. Dete of D Month APRIL		еу - 1 (9 9 7	3. Time of Do	eeth
Medicai caminer	4	a. Fecility Neme (f	f not institution						- 7		Fown, or Location of Deeth 4c. County of Deeth					
	ı	301 🕏	TONES	AVE.	STONI	ER AV	Ε.			WESTMIN	STER Carroll					
	5	5. Social Security Number 219-74-6678 6. Sex 1 M 2 F 7. Age (in yrs. last birtho				Vrs Months Deys Hours Min. (Mo				Birth Dey, Yea 12,	r) 1969		hplece (Stete or Fountry) MD	oreign		
	+															
tor		Da. State 10b. County 10c. Ci MD Carroll 10c. Ci Oe. Street end Number				10c. City,		Location stminst	er						10d. Inside City	
ai Director		0e. Street end Nur 301 Sto			10f. Zip Code 21157				-	itizen of						
by Funeral		Maritel Status Never Marri Widowed	ecedent E Forces? s 2 N Give r Detes:	Ever in U,S ło	5. 13	13. Wes Decedent of Hispenic Origin? (If Yes, specify Cuben, Mexican, Pue 1 ☐ Yes 2 Z No Specify:			ecify Yes or N Rican, etc.)	lo-		ck, Whit	rican Indien, e, etc. White			
Be Completed	npiered	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or				+)	cedent's Usuel Occupetion ve kind of work done during most of worki DO NOT use retired)			orking 16b. Kir		Kind of E	nd of Business/Industry			
Coo	_			2+	2+		ar	tist				m	usic	c & art		
	1	7. Fether's Neme	(First, Middle,	Last)						18. Mother's Nem	e (First, Midd	le, Meide	n Sume	me)		
P	-	Kenneth 19e. Informent's Na	ame/Reletions	hlp (Type, Print)						end Number or Rur		ber, City	or Town	, Stete, 2		
		Kenneth	Shook	, father			30	1 Stone	r	Avenue, W	estmin	ster	, MD	211	.57	
	2	20a. Method of Disposition 1 ⊠ Buriel 2 □ Cremation 3 □ Removel from State							r ple	ca) 5/03/97 Cemetery	Dete				Town, Stete	
	2	21. Signature of Funeral Service Licensee 22. Name and Addres							gdre asl	Funeral H hington R	ome & d., We	Chap stmi	el nste	er, M	ID 21157	
an cal		23a. Pert1. Enter the shock, or heel mmediate Ceuse (disease or condition	rt failure. List Finel	only one ceuse or	n each lin	the deeth.		nter the mode o	of dylr	ng, such es cardlac	or respiretory	errest,			Approximate Intervel Betwe Onset end Dec	an eth

Completed by Physician/Medical Examiner Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burish-transit one pipelately filled in by the funeral director, page 2 should be deteched for use as the burish-transit

Division of Vital Records, P.O. Box 68760.

23a. Pert1. Enter the diseese, or shock, or heert failure. List	complicetions to only one ceuse	net caused the deeth. Do not enter the mode of dying, such es cardiac on each line.	c or respiretory errest,	Approximate Intervel Between Onset end Deeth
Immediate Ceuse (Finel diseese or condition resulting in deeth)	e. C	ARDIAC ARRHYTHMIA		
resulting in deed in		Due to (or es e consequenca of):		
	b	20		
Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying	,	Due to (or es e consequenca of):		
Cause (Diseese or Injury thet initieted events resulting in deeth) Lest	C	Due to (or es e consequence of):		
	d			
Pert II. Other significant condition	ons contributing	to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco use co	entributs to the cause of deati
			1 ☐ Y98 2 🕱 No	3 Probably 4 Unknow
			24e. Wes en eutopsy performed?	24b. Were eutopsy findings eveileble prior to

completion of cause of deeth? 1 Yes 2 No 1 Yes 2 □ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: Medical Certification: To Other: 4 Nursing Home 5 Nesidence 8 Other (Specify) 1XYes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Sending investigation XX Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one)

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, and due to the cause(s) end manner stated.

& Wright MD

29c. License number 29d. Date signed (Month, Dey, Year)

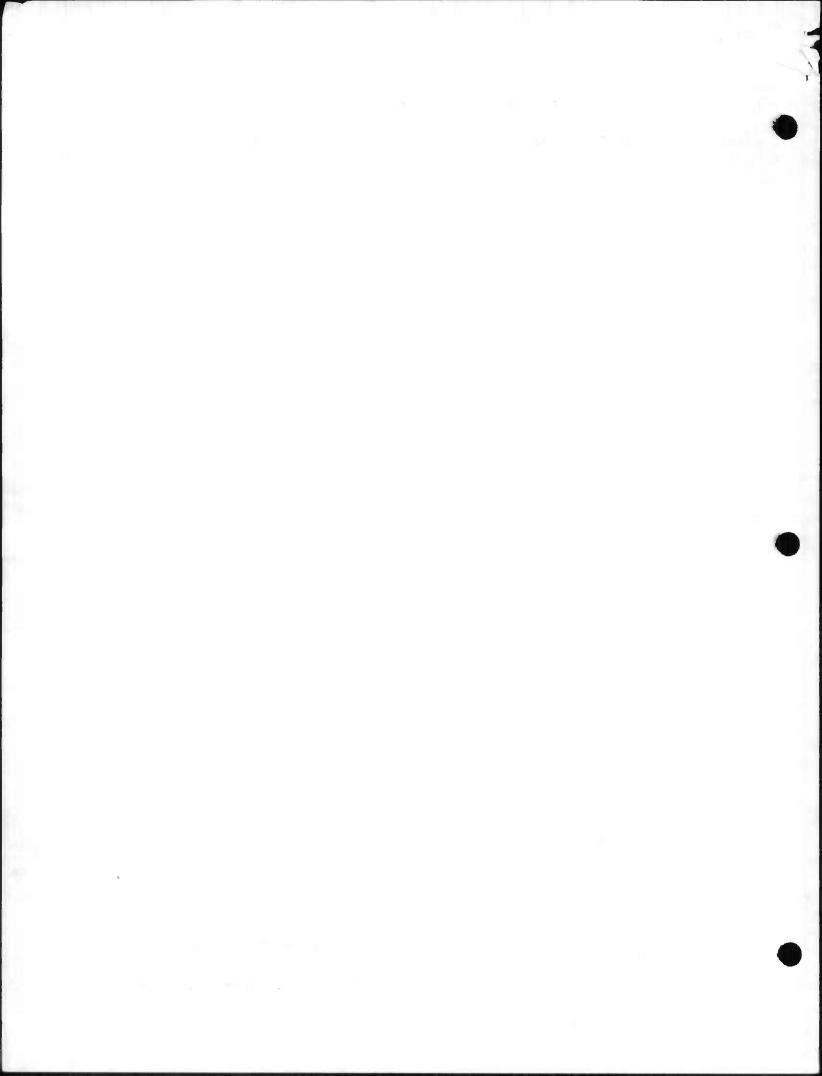
> O.C.M.E. APRIL 29, 1997

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DONALD G WRIGHT 31. Dete filed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 32. Registrar's Signeture



Pruneral Director Funeral Status Ministry Ministry Ministry Ministry Ministry Ministry Ministry Ministry Ministry Ministry Ministry Ministry Ministry Minis	2. Date of Deeth	0	2 There of D
Social Security Number Social Security Num	APRIC cation of Death	Dey	Year 1230 P
The company of the	8. Date of Birth (Month, Day,) NOV 25,	Year)	9. Birthpiace (State or Ford Country) ASHINGTON,
Amend Force 2 Married 3 Middowed 4 Dyhoroced 1 Yes 2 DNo Specify: 15. Decedant's Education (Specify only highest prade complated) 15. Decedant's Education (Specify only highest prade complated) 16. Decedant's Usual Occurry (Specify): 17. Father's Name (First, Middle, Last) WILLIAM HALE 18. Informant's Name/Flaitionship (Type, Print) SHIRLEY ANN MCKNIGHT (DAUGHTER) 3265 PRINCE RA 20. Method of Disposition 1. Peur at 2 Caramation 3 Removal from State 4. Do Place of Disposition (Name of cerelatory crimeral Service Licensee) 21. Signatury of Funeral Service Licensee 22. Name, and Address (Streat and Number or Rural F. SHIRLEY ANN MCKNIGHT (DAUGHTER) 3265 PRINCE RA 20. Method of Disposition (Name of cerelatory crimeral Service Licensee) 22. Name, and Address (Streat and Number or Rural F. SHIRLEY ANN MCKNIGHT (DAUGHTER) 3265 PRINCE RA 23. Peart Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiec or resulting in death) 23. Peart Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiec or resulting in death) 24. Sequentially list conditions, if any, leading to immediate Cause (Final disease or complications) that caused the death. Do not antar the mode of dying, such as cardiec or resulting in death) 25. Was case referred to medical axis miner? 26. Due to (or as a consequence of): 27. Manne, and Address (Streat and Number or Rural F. SHIRLEY ANN F. SH	10	Og. Citizen of Wh	10d. Insida City Lim
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25. Was case referred to medical axaminar? 1	24e. Wes en o	eutopsy red?	24b. Wara autopsy findin eveileble prior to completion of causa of daath?
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27. Manner of Death 1 Natural 2 Accident 3 Sulcide 4 Homicide 28a. Data of Injury (Month, Day Year) 28b. Tima of Injury M 28c. Injury at Work? 1 Yas 2 No 28d. Place of Injury - At homa, farm, streat, factory, office 28d. Data of Injury 28d. Data of Inj			(Specify)
286. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify)	8d. Dascribe how		
5 00 Cod. Collision 129 Collision business to the page of the page 401 and 401 a	City or Town,	, State)	or Rural Route Number,
29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledga, daath occurred at tha tima, date and place, and coursed and manner stated.	d at the time, date	ta and place, and	d due to tha ceusa(s)
29b. Storusture and titla of certifiar 29c. Licensa number	29d	d. Data signed ((Month, Day, Year)
30. Name and address of person who complated ceuse of death (Itam 23a) (Type, Print) 11. P. W. 1. 3. of 5. by 200 Old Line Centrus 31. Date filed (Month Phy (Year))	A	HIMIL	24, 1991

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 202 AM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 6901 PRINCE YYC FIL G EOAGE(If Under 1 If Undar 24 Hrs. Hours Min. Birthplace (Steta or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 10 M 2□ F Director 150-05-1066 80 June 6, 1916 New Jersey Usuel Rasidance of Decedent pemit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or ferms 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified enough. 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 No Director Maryland | Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10301 Old Fort Road 20744 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 [A'yas 2□ No If Yes, Give Yaar or Detes: 1947-52 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 11. Maritel Stetus 14. Race - Amarican Indian, Black, White, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Federal Government Mechanical Technician 17. Fether's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) 8 2 Saverano John Spano Anna 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Marie A. Spano/Wife 10301 Old Fort Rd. Ft. Washington, Md. 20744 20e. Method of Disposition
1 ☑ Burlai 2 ☐ Cremetion 3 ☐ Removel from Steta 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20c. Location - City or Town, Stete Maryland Veterans Cem. 4/29/97 4 ☐ Doptation 5 ☐ Other (Specify) Cheltenham, Maryland 22. Nama and Addrass of Fecility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 or complications that caused the deeth. Do not entar tha mode of dying, such as cardiac or respiratory errest, List only one cause on each line. 23a. Pert . Enter the dissipation shock, or heart feil and Approximete Interval Between Onset and Death Physician Immediate Cause (Final diseasa or condition rasulting in death) DISTAUCTUR PULMONARY
32A3210 SITCOURSERORS /Medical · CHRONIC YEARS Examiner Due to (or es e consequence of): Physician/Medical Examiner physician and the buriel-transit The law requires that the death certificete be axecuted Sequentially list conditions, if any, leading to immadiate cause. Enter Undarfying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Dua to (or as a consequence of): USB as signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown ğ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, Be 25. Wes casa refarred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) P 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Se Neturel 5 Pending Invastigetion death. 1 ☐ Yes 2 ☐ No 2 Accident efter death Director: 6 Could not ba 3 ☐ Suicida 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital hours . 24 hours 156 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the bests of examinetion end/or invastigetion, in my opinion, deeth occurred et the time, dete end pieca, and dua to the ceuse(s) and menner steted. edicai 29e. Certifier (Check only one) within 2 29b. Signeture and title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 2 xm ddress of person who completed cause of deeth (item 23e) (Type, Print) WISETSKY PHILIP La. D-11701 Livingston Rd. Ft. Wash., Md. 20744

State Registrar

31. Dete filed (Month, Dey, Year)

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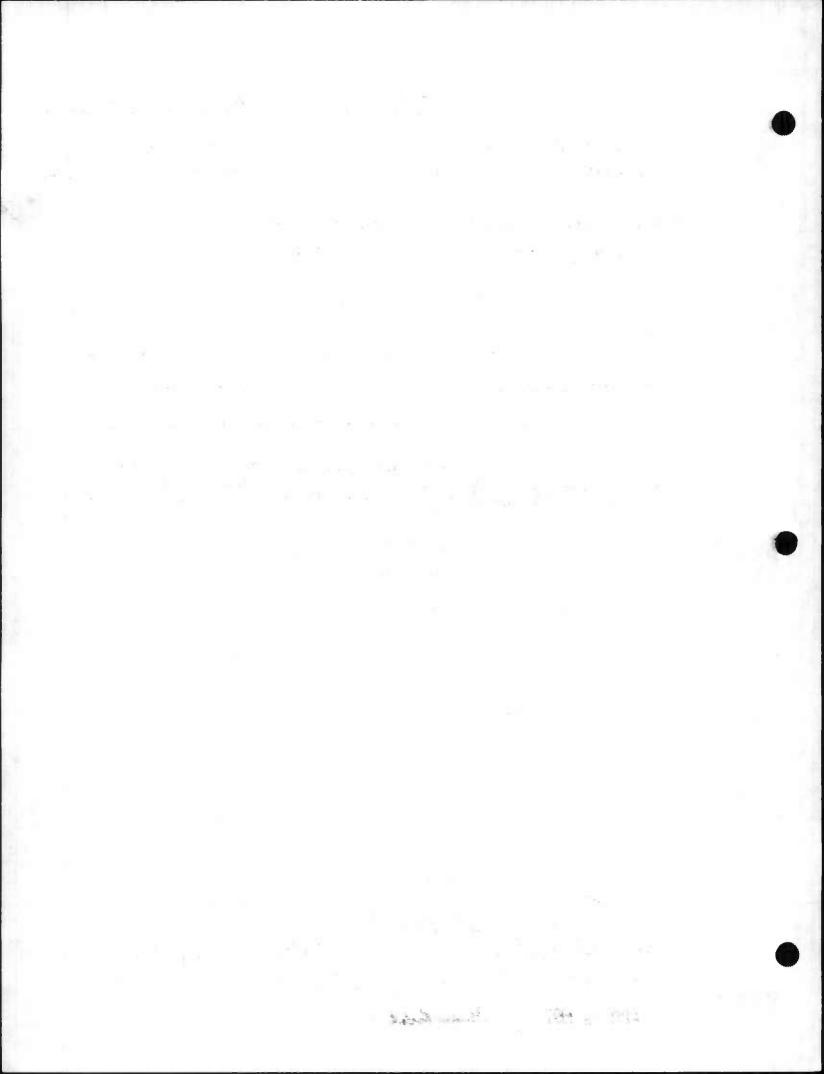
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ntal Hygiene. Id other than "natur event, the Medical	Completed	15. Decedant's (Specify only highest	Education grade completed)	16e. Da	cedent's Usuel Oc iva <i>kind of work do</i> a. <i>DO NOT</i> use re	cupation one during most o	of working	16b. Kind of B	usiness/Ind	lustry
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end Mental Hygiene. Is merked other than raumatic event, the M		19e. Informent's Name/Relationshi	o (Type, Print)	19b. Me	eiling Address (Str	eet and Number	or Rural Routa Num	ber, City or Town	, Stete, Zip	Code)
t Health end Mer Item 27 is merke other traumetic		Gary B. Stanley	//Brother	5	Joiner	s Road.	Rocky Hil	1. Ct 0	06067	
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두루를 !	-			Angela F	aye Memori		4/26/97			, N.C.
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within 24 hours efter deeth. To the Funeral Director: Aft completely filled in by the fur.	edical	(Check only 2 Medical Ex	aminer: On the basis of end manner stat	examinetion and/or	Investigetion, in m	y opinion, deeth	occurred et the time	, dete and plece,	and due to	the cause(s)
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State of Maryland / Department of Health and Mental Hygiene

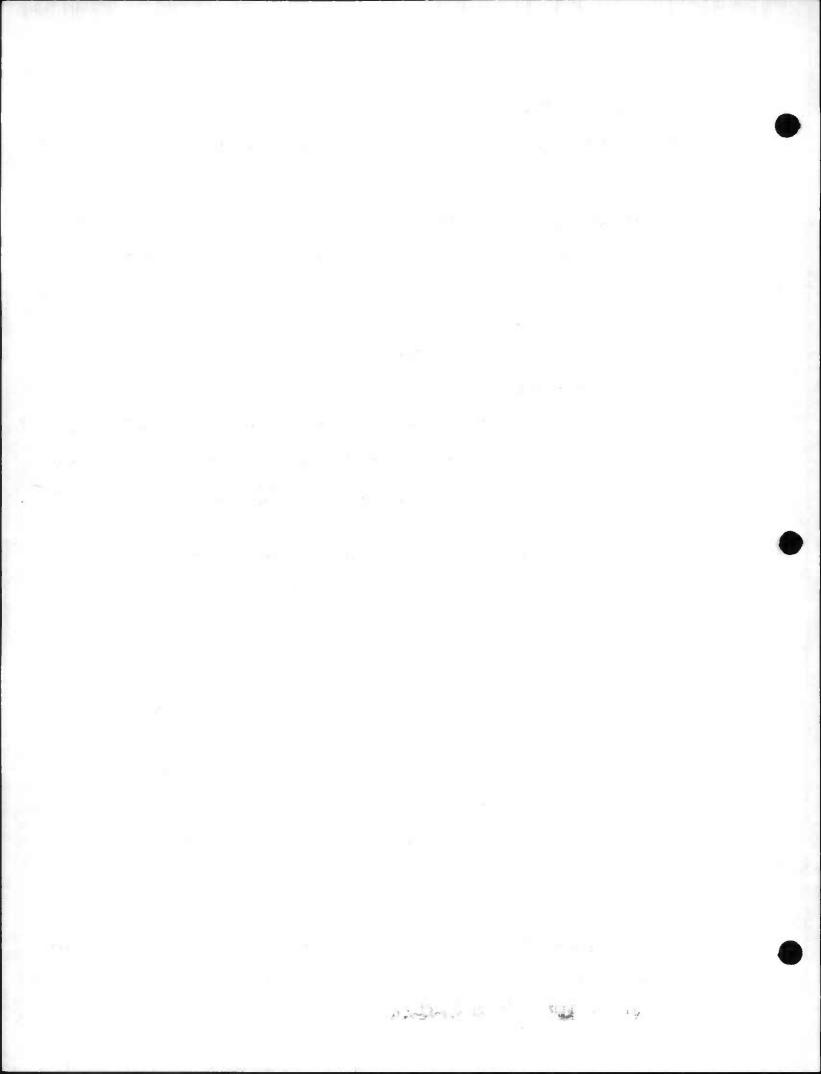
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21215-0020 d within 72 hours after death with the Maryland jiene.	rthan "natural", or itams 23a or 26e-f show the Medical Examiner must be notified at	by		rried 2 Married 4 Divorcad	1 Tas If Yas, Give Year or Da	a		1□Yas 2⁄CIN						-AMERICAN
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VISION Attending or death.	the	icat	2 Accident 3 Suicida	invastigatio	10				Yes 2		004 1	04-14-14	h	10-11
DIVISION or Attending	at Director: After trees and in by the funere	Certification:	4 Homicide	detarminad	buildin	g, atc. (Specify	ma, tarm, str	aat, factory, office	9		City or To	vn, State)	ber or Hur	al Routa Number,
Hospital 24 hours	tely fill	edicai C	29a. Cartifier (Check only one)	Cartifying Ph	nysician: To the baseliner: On the baseliner	sis of exeminat	vledge, death ion end/or inv	occurred at tha vastigation, in my	tima, data an opinion, dea	d piece, ith occurr	end due to the ed at tha tima,	ceuse(s) and m data and place	ennar as s and dua t	otated. o the cause(s)
To the	comp	Me	29b. Signature	title of certifiar	1				nsa number			29d. Data sign		
1	1		1	ail a	das	ہ نہ	an	250	367	_		4/2	1/9	7
1	()	-	30. Nama and add	ress of person who	completed cause	of death (item	23a) (Type,	Print)	1			/	11	7- PRING, M
1			DAVI	DA.	SARC.	N, N	10	Hory	CR635	N	e ST	SILVE	RS	PRING, N
	Sta	-	31. Data filed (Moi	nth, Day Yaar)	ilin di aut	gistrer's Signat	ura							/ /
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or shows the law.

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			Certificate of Maryland / Department of		, ,	Rag. No.	14898			
ı	Physici	an	1. Decedent's Name (First, Middla, Lest)		2. Date of Dee Month	Dev Yeer				
Į.	/Medic	cai	COLIN RAY SUTHERLAND 4e. Fecility Nema (If not institution, give street end number)	4b. City, Town, or Lo	April	22 199	1.			
а	Examir	ier								
	Funerai Director		HOLY CROSS HOSPITAL 5. Social Security Number 6. Sex 1 N/A 1 N 2 F 7. Age (In yrs. lest birthday) Yrs. 1 N 2 F 1 N 2 F	ys Hours Min.	8. Date of Birth (Month, Dey	MONTGOMERY COUNTY Birth Dey, Year) 20, 1997 MARYLAND				
	hand wo		Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location				10d. Inside City Limits			
	er death with the Marylan Items 23a or 28a-f show net must be notified at	tor	MARYLAND ANNE ARUNDEL EDGEWATER				1 N Yes 2 No			
	or 28	Director	10e. Street end Number 10f. Zip Code	9	1	10g. Citizen of Whet C	ountry?			
	ath w			1037	1	UNITED STA	TES			
21215-0020	a within 72 hours efter death with the Maryland ijene. Than "natural", or items 23a or 28a-f show the Medical Expression of the must be notified at	by Funeral	11. Maritel Status 1 1 Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Wes Decadent Ever in U,S. Armed Forces? 1 □ Yas 2 No If Yes, Give Yeer or Detes: 13. Was Decedent of If Yes, specify Ct. If Yes, Sive Yeer or Detes:	of Hispenic Orlgin? (Spi uben, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	Bleck, Whi				
5-0	72 ho	eted	15. Decedant's Education 16e. Decedent's Usual Occ (Specify only highest grade complated) (Giva kind of work don	cupation ne during most of work	ring	16b. Kind of Business	s/Industry			
121	within iene. than	Completed	Elamentery/Secondary (0-12) Collaga (1-4or 5+) // life. DO NOT use reti	ired)		27 / 4				
	be filed tral Hygie d other event, to		O O N/A 17. Fathar's Neme (First, Middle, Last)	18. Mother's Neme	e (First, Middle,	N/A Malden Sumeme)				
Maryland		To Be	ALVIN RAY SUTHERLAND	ROBIN H	. HARRIS	3				
lan	2 should and Men Is marke		19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Stre				Zip Code)			
	rt 27		ALVIN R. SUTHERLAND, FATHER 416 HIGHLAND	DRIVE, ED						
Baltimore,	permit. Pages 1 a Department of Hei Important: if Item any injury or othe		20e. Method of Disposition 1 XBuriel 2 ☐ Crametion 3 ☐ Removel from State 20b. Plece of Disposition (Name of cemetery, cremetory or other p	n/ece)	Dete	20c. Location - City or	Town, State			
Ē	permit. Page Department of Importent: If any injury or once.		4 □ Donetion 5 □ Other (Specify) FORT LINCOLN CEMP 21. Signeture of Funerel Service Licansea 22. Name end Add		4/25/97	BRENTWOOD	, MARYLAND			
Ba	Depariment Department Important Irraportan		FORT LINCO	OLN FUNERAL						
			23e. Pert1. Enter the disaase, or complications that caused the death. Do not enter the mode of dishock, or heart failura. List only one cause on aach line.	ENSBURG RD tying, such es cardiec of	 BRENT or respiretory err 	TWOOD, MD	Approximete			
	Physician /Medical Examiner		tmmediata Ceuse (Final disease or condition MASSI INTRAVENTS (U)	ar hemmi	orhag:	e	Interval Between Onset end Deeth			
	Examine	<u>-</u>	resulting in death) Dua to (or as a consequence of):	,	.1.1.					
	uted d Bnsit	Examiner	Sequentially list conditions. Prematurity at Zb Dua to (or es-econsequence of):	weeks q	estati	071	1			
Ó	an en	Еха	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disaese or injury c.							
68760,	ifficete be executed g physician end as the burial-trensit	edical	Ceuse (Disaese or injury that initialed evants resulting in deeth) Lest Due to (or es e consequence of):							
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Вох	seath certi ettending d for use a	clar	Post II. Other classificant conditions are still also as s				1			
s, P.O.	res that the de signed by the e be deteched f	by Physician/N	Pert II. Other eigniftcant conditions contributing to death but not resulting in the underlying cause of	given in Pert I.	23b. Did to	~ ~	e to the cause of death? Probably 4 Unknown			
Records, P.O.	aw requi	Completed			24a. Was a perform		Ware autopsy findings eveilable prior to completion of cause of daeth?			
		Соп			1 🗆 Y	es WINO	1 ☐ Yes 2 ☐ No			
Vita	Physician: The rthis certificate rail director, pag	Be	25. Wes casa raferred to medical exeminer?	26. Plece of Deeth	h (Chack only or	10)				
-	5 00	5.7	1 Department 2 ER/Outpetient 3 DOA			ence 6 Other (Spe	ecify)			
on	ath. : Afte	ation	1∠Naturel 5 Pending (Month, Dey Year) Injury W	Vork? □ Yes \□No	^	//A				
Division of	or Attender design by the	Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	:е	28f. Location (Si City or Town	treet and Number or R n, State)	lurel Route Number,			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After thi completely filled in by the funeral	edical Ce	29a. Certifier (Check only one) 29a CertifyIng Phyelclan: To the best of my knowledge, deeth occurred et the 2 ☐ Medical Examiner: On the best of axamination end/or investigetion, in my end menner stated.	time, deta end plece, or opinion, deeth occurr	end due to the c	ause(s) end menner e ata end place, and du	s steted. e to the causa(s)			
	within To the	Me	29b. Signeture end titla of certifier 29c. Licer	ense number		9d. Dete signed (Mon				
			my mon vil	32425	. /	April 22,	1997			
			30. Nema and addrass of parson who completed causa of death (Itam 23a) (Type, Print) Margaret Chou, M.D. Hdy Ch	ross Host	Hal, S	Silver Spr	1997-			
	Sta Registr		31. Dete filed (Month, Day, Year) 32. Registrer's Signeture				J			



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State of Maryland / Department of Health and Mental Hygiene

97

						Certific	ate of	Death		Reg. No.	J 1	14000	
	Physic	ian	Decedent's Name (First, Middle, Las	•					2. Data of D Month	eath Day	Yaar	3. Time of Death	
S	/Medi			HN SMIT	Н				APRIL	. 1		23:15	
7	Examinum Funeral Director	ner	4a. Facility Nama (If not Institution, give SHADY GROVE A 5. Social Security Number 6. St. 218-21-7695	DVENTIST	HOSP (In yrs. last bir		nder 1 Yae		SBURG s. 8. Data of B	MONT(GOMER' 9. Birthpla Country SIERRA	Y ca (Stata or Foraign V) LEONE, W	
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	h the Marylend r 28a-f show	Director	MARYLAND MONTGO 10e. Street end Number	MERY	GAITH	ERSBUR	G . Zip Code			1 Yes 2 □ No			
	fler death with it flems 23a or in iner must be n		14 PRAIRIE ROSE L				20878		SIER		LEONE, RICA ce - American		
7020	el', or	by Funeral	11. Marital Status 1 □ Nevar Married 2 ☑ Merried 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yeer or Detes:	er in U,S.		ecedant of specify Cu	Hispenic Orlgin? (ban, Mexican, Pue Specify:	Specify Yas or N into Rican, atc.)	Bie	ce - American ack, White, etc fy: BLAC	C.	
7707-61717	2 E E	Completed	15. Decedant's Ed (Specify only highast grad	da completed)		Decedent's (Giva kind o	f work don	a during most of w	orking	16b. Kind of E	Businass/Indu	stry	
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Y	should be and Mental i marked o umatic eve	10	FAWNDA KEBBIE SM	ITH					O_KEBE_				
3	2 short and is ma		19a. Informant's Name/Raiationship (7					et and Number or I					
Ď	Heal Hem 2 other		DAISY MANSAKAHN 20a. Mathod of Disposition 1\overline{\Omega} Buriai 2 \(\text{Cremetion } 3 \) 4 \(\text{Donation } 5 \) Othar (Specify	Ramoval from State	20b. Place of cemate		(Neme of or other p	(ece)	O5/09	20c. Location	- City or Town	AND 20878 n, Stata RYLAND	
	permit. Peges Department of important: If it any injury or once.		21. Signatura of Funarai Service Licen	sea -	12110101	22. Nem	e and Add	rass of Fecility KINS FUN		AP.			
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K.	/Medical Examiner	ler	Immediata Causa (Final disaesa or condition rasulting in death)	a. MYOCARD.	IAL INI						a	cute	
500	eeth certificate be asscuted attending physician and i for use es the buriel-transit	al Examiner	Sequantially list conditions, if any, leading to immediate ceuse. Entar Undartyling Cause (Olsease or Injury	b. Du	ua to (or as a	consequance	of):						
OX 00/00,	n certificate Inding physical use es the I	n/Medical	that initieted evants rasulting in death) Last	d.	a to (or as a d	consequence	of):						
	the deeth y the atter sched for	sicia	Part II. Other significant conditions co	ntributing to death but	not rasuiting in	the underlyi	no causa o	iven in Part I.	23b. Did	i tobacco usa c	ontributs to t	he cause of death?	
		by Physician/							10	Yss 2□ No	3 Probe	bly 🛧 Unknown	
vital necolus,	a lew requires thet hes been signed b ge 2 should be det	Completed b							24a. Wa	s an autopsy formed?	avail	e autopsy findings able prior to plation of cause eath?	
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	ysician: The s certificate director, pag	Be	25. Was casa rafarred to medicel axaminar?	Hospitai:					eath (Check only	ona)			
	this aldi	٦: <u>٦</u>	27. Mannar of Death	26a. Data of Injury	26b. 7	Tima of	DOA 28c. Inj		Homa 5 ☐ Ras 26d. Dascribe	how injury occu			
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the lune	Certification:	1 🖺 Natural 5 🗆 Panding 2 🗆 Accident Invastigation 3 🗆 Suicide 6 🗆 Could not be detarmined	(Month, Day') 28a. Place of Injury building, atc.	- At homa, fa	m, straet, fa	1[Yas 2□No	26t. Location City or To	(Street and Num own, Stata)	ber or Rural f	Route Number,	
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(Sta	te	31. Data filed (Month, Day, Year)	MAYLE	02/5 Signature	FERN	1 Was	0018	BETHE	SOA M	10 20	7 180	

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** GEORGE G. TALBOT JR. April 23,1997 7 A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Springbrook Adventist Nursing Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Daie of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Daie of Birth (Month, Day, Year)

March 15, 1924 So. Carolina **Funeral** Monihs 212 20 5591 Director 73 Usual Residence of Decedeni the Maryland r 28a-f show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Prince Georges Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23a or treumatic event, the Medical Examinational bear 8302 Rosette Lane 20783 U.S.A. Funeral 12. Was Decedeni Ever In U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedeni of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Raca - American Indian, Black, While, etc. 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 XNo Specify: White þ Specify: 3 Widowed 4 Divorced "natural", Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene Important: If item 27 is marked other than "n any injury or other treumatic event. Elementary/Secondary (0-12) Coilege (1-4or 5+) Lithographer Westland Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be George Gladstone Talbot Laura Belle Hooper 2 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adele S. Talbot Spouse 8302 Rosette Lane, Adelphi, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 4-26-97 Baltimore, Maryland 22. Name and Address of Fedlity Takona Funeral Home, Inc. 21. Signature of Funeral San 254 Carroll St. NW, Washington, D.C. 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause of each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting In death) emen Examiner Physician/Medical Examiner physician and the bunal-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury thai Initiated events resulting in death) Last P.O. Box 68760, Due to (or as a consequence of): 50 attending p 950 been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Records. þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed page 2 certificate 1 Yes No No No No 1 Yes Division of Vital septral or Attending Physician: hours after death.
Ineral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth
1 Naturel
2 ☐ Accident 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) in by 4 Homicide Pellil To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of certifier 29c.-License number 29d. Dele signed (Month, Day, Year) 30 (Name end address of person who completed cause of deeth (Item 23a) (Type, Print) Armstrong. PARK Dr. LAUre 1, md. 20707 14201 LAUrel m.n 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Julia Davidson

DHMH 16 Rev 6/95

Registrar

APR 28 1997

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Physician MERVIN THOMAS APRIL /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year 5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthdey) If Undar 24 Hrs. Birthplaca (Stete or Foreign Country) 8. Dete of Birth (Month, Dev. Year) **Funeral** 1**X**0 M 2□ F Months Days Hours 281-05-9932 84 Director JAN. 15,1913 OHIO Usuei Residenca of Decedent the Menyland 10b. County 10c. City. Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at Director 1 X Yas 2 □ No MD. MONTGOMERY SILVER SPRING 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? or items 23a or 3701 INTERNATIONAL DR. #335 20906 Funeral U.S.A. 12. Was Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indien, Bleck, Whita, etc. 11. Merital Status 1 XYes 2 No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: p Specify 3 ☐ Widowed 4 ☐ Divorced Yaer or Detes: WWII natural', WHITE Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Hygiene. Elemantary/Secondery (0-12) College (1-4or 5+) AREA 12 MANAGER COLUMBIA GAS CO. Pages 1 end 2 should be filed a nent of Health end Mentel Hygie int: If Item 27 Is marked other? 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be FRANK THOMAS PEART. BONER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2: Department of Health et Important: If Item 27 Is any Injury or other trau MERVIN E. THOMAS/SON FAIRWAY CIR, NORWALK, OHIO 44857-1902 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) SYLVAN HEIGHTS CEMETERY 4/30 UNIONTOWN, PA. 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility rancellan CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 M00091 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Beckerial Endocarditis Immediate Ceuse (Finel disaese or condition resulting in deeth) /Medical Examiner Examiner physician and s the burial-transit The law requires that the death certificeta be executed Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Ceuse (Diseese or injury that initieted events rasulting in deeth) Last Due to (or es e consequence of): Box 68760, Physician/Medical the Due to (or as a consequence of) 98 P.0. signed by the a Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Cancer 1 Yes 2□ No 3 Probably 4 Unknown Records, þ Completed 24b. Were autopsy findings aveileble prior to completion of cause of deeth? 24e. Wes an autopsy performed? peen Emplysema has certificate 1 Yes Division of Vital Be 25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Phy within 24 hours efter death.

To the Funeral Director: After this completaly filled in by the funeral is 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Routa Number, City or Town, State) 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Spacify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated. 29b. Signeture end title of certifing 29c. License number 29d. Date signed (Month, Dey, Year) 036797 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Sheff Fernwood Rd, Bothesda 10215 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State who Davidson Registrar 28

Silver in regressive as a and grant Restriction of the Application of the State of the Contract of the C

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State of Maryland / Department of Health and Mental Hygiene

	Decedant's Nama (First, Middla,	(and		Certifica	ate of L	Death		Reg. No.	37	4902
ian							2. Data of Da Month	Day	Yaar	3. Time of Death
cai	Joanne Gandy Tr						April 2	23, 199	7	10:50am
ner	4a. Facility Nama (If not institution,	giva street and number)			4	b. City, Town, or	Location of Death	4c. Count	y of Death	
	3596 Watersvill	e Road				Mt. Air	V	Carr	011	
г			e (In yrs. last t		dar 1 Yaar	if Undar 24 Hrs	8. Data of Birt			a (Stata or Foreig
	220-32-7233 Usual Rasidance of Decedant	1□M 21XF	60	Yrs. Month	s Days	Hours Min	June 2	y, Year) 7, 1936	Baltir	nore, MD
	10a. Stata 10b. County		10c. City, To	wn or Location					10d.	Insida City Limit
tor	Maryland Carrol	1	Mt.	Airy						1 ☐ Yas 2 ☑ No
Directo	10e. Street and Numbar			10f. 2	ZIp Code		T	10g. Citizan of	What Country	?
0	3596 Watersville	Pond		2	1771			United	Ctoto	
era	11. Marital Status	12. Was Decedant 6	var in U.S.			spanic Origin? (Specify Vas or No.	-	ce - Amaricen	
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by	3 □ Widowed 4 □ Divorced	If Yas, Giva Yaar or Datas:	10	1 ☐ Yas	2⊠ No	Spacify:		Specia		
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E	12	College (1-4or 5		Executiv	e Sec	retary		Marr	iott Co	arn.
Be C	17. Father's Nama (First, Middla, La	ast)		ACCUCIV	C BCC		ma (First, Middla,			orb.
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							u <i>ral Rou</i> ta Numbe			oda)
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	23a. Part1. Enter the disease, or co shock, or heart failure. List or	ompliantions that sourced	the death. De	Gaith	ersbur	g, MD 2	0877		7	
	shock, or haart failura. List or	nly ona cause on each lin	a.	THOLEHICA (NE III	oda oi dyiriş	y, such as cerula	c or raspiratory at	1851,	In	pproximata tarval Batween nsat and Death
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14	rasulting in death)		Dua to (or as a	consequence o	f):					, , , , , , , , , , , , , , , , , , , ,
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ũ	Sequentially list conditions, if any, laading to immadiate ceusa. Entar Underlying Causa (Diseesa or injury								1	
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Certification:	4 ☐ Homicide determine	28a. Place of Inju building, atc.	(Specify)	arm, street, tacto	огу, опісе		28f. Location (S City or Tow		er or murai m	oute Number,
edical	29a. Certifiar 1⊠ Certifying I (Check only 2 Medical Ex	Physician: To the best of aminar: On the basis of and mannar stat	axamination a	a, deeth occurre nd/or invastigetio	d at tha time on, In my op	e, dete and place Inion, daath occu	e, and due to the curred at tha tima, c	ausa(s) and ma data and place,	annar es state and dua to the	d. e ceusa(s)
N N	29b. Signature and the of certifier	and marmar stat	au.	2	9c. Licansa	number		20d Data siana	d /Manth Da	Vessl
-	· AL	1				-	•	29d. Data signe	a (Month, Day	, rear)
	1/8/1)	enna			01	5046		April 2	3, 199	7
			ath /Itam 23a)	(Type Print)				-		
	30. Nama and address of parson wh	o complated ceusa of da	atti (Italii 20a)	(., 100,						
					ge Av	enue. G	aithersh	urg. MD	20879-	-2025
te.	30. Nama and address of parson who Stephen J. Newma. 31. Data filad (Month, Day, Year)	n, 19261 Mo	ntgome:	ry Villa		enue, G	aithersb	urg, MD	20879-	-2025
te ar	Stephen J. Newma 31. Data filad (Month, Day, Year)	n, 19261 Mo	ntgome:	ry Villa		enue, G	aithersb	urg, MD	20879-	-2025
-	Stephen J. Newma 31. Data filad (Month, Day, Year)	n, 19261 Mo	ntgome			enue, G	aithersb	urg, MD	20879-	-2025

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

14903 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth Dey Month **Physician** Barbara E. Thomas 7:20 PM April 24, 1997 /Medical 4a. Fecility Neme (If not institution, give street end number) 4b, City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 18700 Walkers Choice Road #515 Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 8. Dete of Birth
(Month, Dey, Year)
March 1, 1913

9. Birthplece (Stete or Foreign
Country)
New York 5. Social Security Number 7. Age (in yrs. iest birthday) **Funeral** 1 □ M 2 🗓 F 84 Yrs. 578-22-7285 Director Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelth end Mental Hygiene. Important: If them 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified an once. 1 ☐ Yes 2 ☒ No Director Maryland Montgomery Gaithersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 18700 Walkers Choice Road #515 20879 United States Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bieck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Arthur J. Leck Eva Carr 2 19e. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) John Calvin Thomas/Son 470 South Union Street, Alexandria, Virginia 22314 20b. Place of Disposition (Neme of cametery, cremetory or other place April 29, 1997 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Parklawn Memorial Park 4 ☐ Donetion 5 ☐ Other (Specify) Rockville, Maryland ROBERT A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee and M00198 23a. Part1. Enter the answer, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Coronary Artery Disease Years **Examiner** Due to (or es e consequence of): Examiner Hypertension Years siclan end buriel-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in deeth) Lest Due to (or es e consequence of): physician s the burie P.O. Box 68760, Physician/Medical Due to (or es e consequence of) ate hes been signed by the ettendin page 2 should be deteched for use Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Carcinoma of Breast Records. þ 24b. Were autopsy findings evelleble prior to Completed 24e. Wes an autopsy performed? completion of cause of death? certificate 1 Yes 2X No 1 Tyes 2 No Division of Vital Hospital or Attending Physician: director. Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1⊠ Yes 2 No this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After 1 1 Naturel 5 Pending efter deeth. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral D 1 McCertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. 29a. Certifier Medical completely f (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) D11946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) April 28, 1997 Sanford N. Richman, M.D. 10215 Fernwood Road, Bethesda, Maryland 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State whia Davidson Registrar APR 2 9 1997

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

ate of	Maryland /	Department	of Health	and	Mental	Hygiene
		Certificate	of Death	7		Dec No

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1	1	Like	3	U	ı
-			and a	V	

Physician
/Medical
Examiner

1. Decedent's Neme (First, Middle, Lest) CHARLES

THOMAS

10c. City. Town or Location.

4b. City, Town, or Location of Deeth

2. Dete of Deeth 3. Time of Death APRIL 14, 1997 4:20 PM.

4c. County of Death

Reg. No.

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, fra Medical Examiner must be notified at

Physician

Examiner

pue

for use as the buriel-transit

page 2 should be

certificate

þ

Be Completed

Certification: To

Medical

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

/Medical

Baltimore, Maryland 21215-0020

Funeral Director

by

Be Completed

2

4e. Fecility Neme (If not institution, give street end number) 802 W. LEXINGTON ST. T . APT . 14

7. Age (In yrs. last birthdey)
64 yrs. 6. Sex NOM 2□ F 578-40-5159

Months

10f. Zip Code

BALTIMORE
If Under 1 Year | If Under 24 Hrs. | 8, Dete of Birth (Month, Day, Year) May 17, 1932

 Birthplace (State or Foreign Country) North Carolina

10a. Stete 10b. County

Usuel Residence of Decedent

Mary land 10e. Street and Number Baltimore

10d. Inside City Limits XX Yes 2□ No

802 West Lexington Street Apt. #14

11 Merital Stetus Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1XXYes 2 □ No

E.

Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

21201

 Rece - American Indien, Bleck, White, etc. Specify: Black

10g. Citizen of Whet Country?

U.S.A.

15. Decedent's Education (Specify only highest grede completed)

College (1-4or 5+)

1 ☐ Yes 2 No Specify: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondery (0-12) 12th grade

Unemployed

N/A

17. Fether's Name (First, Middle, Last)

Paul Thomas

18. Mother's Name (First, Middle, Meiden Surname) Sadie McCain

19e. Informent's Neme/Reletionship (Type, Print)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1131B Sursum Corda Court Washington, D.C. 20001

Mr. Edward Thomas (Brother) 20e. Method of Disposition

20b. Pleca of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory, Inc.

Date 20c. Locetion - City or Town, Stete

Beltsville, MD

1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

22. Name and Address of Fecility Rollins Funeral Home, Inc.

4339 Hunt Place, N.E. Washington, D.C. 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth

4/24/97

Immediate Cause (Finel diseese or condition resulting in death)

Cardinaculos Disene

Physician/Medical Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest

Due to (or es e consequence of):

RUSER

Due to (or es e consequenca of):

1 Yee 2 No 3 Probably 4 Unknown

23b. Did tobacco use contribute to the cause of death?

24e. Wes en eutopsy performed?

24b. Were eutopsy findings eveilable prior to completion of cause of deeth?

2 No 1 Yes

25. Wes case referred to medical 1X Yes 2 No

27. Menner of Deeth 5 Pending investigation

28e. Dete of Injury (Month, Dey Year)

Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 ☐ Nursing Home 5 🖔 Residenca 6 ☐ Other (Specify) 28d. Describe how injury occurred

29e. Certifier (Check only one)

2 Accident

3 SuicIde

4 T Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end pleca, end due to the ceuse(a) end menner steted.

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, Stete)

O.C.M.E.

APRIL 15, 1997

30. Name end eddress of person who completed cause of thath (Item 23e) (Type, Print)

THEODORE MIKE-

111 Penn Street, Baltimore, Maryland 21201

26. Piece of Death (Check only one)

31. Dete filed (*Month, Dey, Year*) **APR** 2 9 1997

DHMH 16 Rev 6/95

To the Hospital or Attanding Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, p

State Registrar

6 Could not be determined

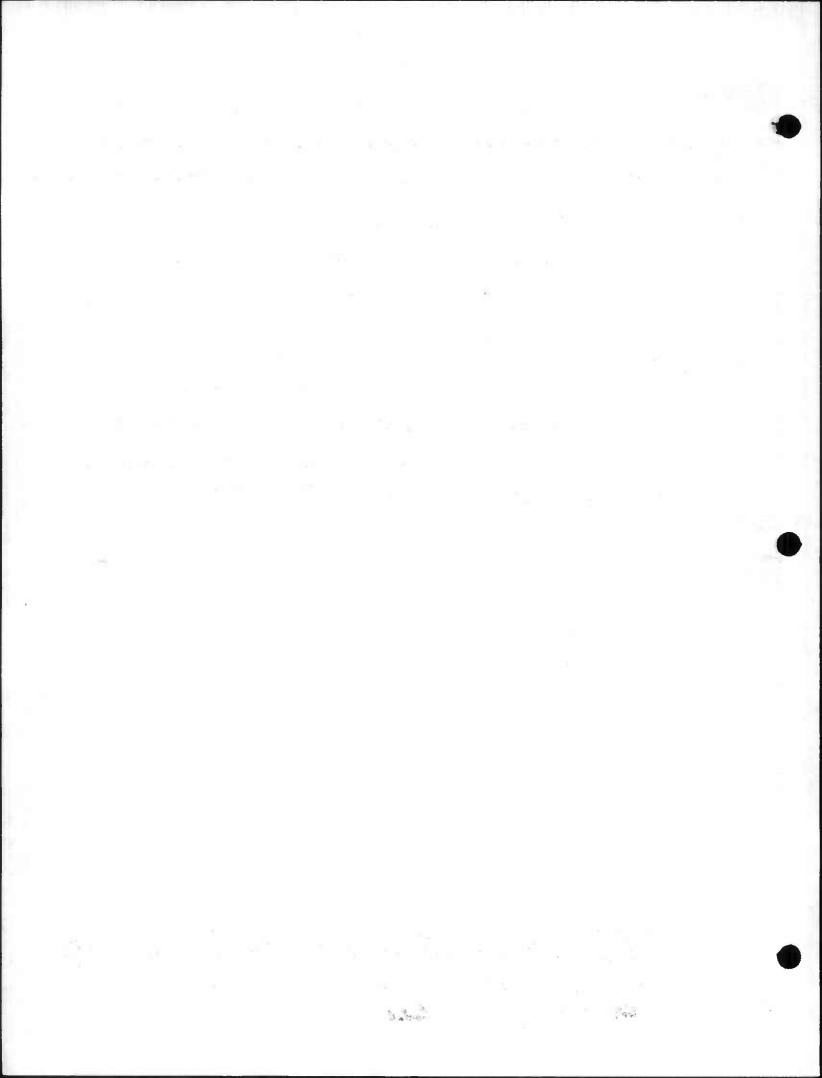
32 Registrar's Signeture

the street is all

E v. Au

				Cei	tificate of	Death	R	eg. No.	9/	14	905
Dhint		1. Decedant's Nama (First, Middle, Last)					2. Data of Deat Month	h Day	Yaar	3. Tima of D	Death
Physic Med /		DUANE FRA	NKLIN	Τ0	LSON		April			10:50	a.m.
Exami		4a. Facility Nama (If not institution, give st	reet and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death		
Funeral		Mariner Health Care 5. Social Security Number 6. Sax	7. Aga (In)	yrs. last birthdey)	and If Under 1 Year Months Days		8. Data of Birth (Month, Dey,	Year)	e Geo	ica (Steta or	Foraign
Director		578-82-8675 Usual Rasidence of Decedant 10a. Stata 10b. County	32	City, Town or Lo	cation		Septemb	er 3, 196	4 Wash	ington	D.C.
DattIIMOFe, Maryiand 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours efter death with the Meryland Depertment of Health and Mentel Hygiene. Important: if them 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinal must be notified at any online.	Funeral Director	N/A N/A	<i>k</i>	lashing	ton D	.С.	1	Og. Citizan of V		Yas a	
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d 2 s lth ar 17 is 17 is		Joseph Tolson /	-,			eaf Ave.					207
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bemit. Pages 1 and popularity of Heal moortant: If Heal my Injury or other MAS.		1 ☐ Burial 2 🛣 Cramation 3 ☐ Ra 4 ☐ Donation 5 ☐ Other (Specify)	moval from Stata				5/1/97	Poltovi	110	MD	
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/Medical Examiner		Immediata Causa (Final disaasa or condition	H.	1.V.						241	5
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requir	Completed b						24a. Was a perform		com	e autopsy fin lable prior to apletion of ca eath?	
The law ata has page 2	E O						1 🗆 Ya	as 212 No	10	Yas 2□N	lo
ysician: The last certificata ha	Be C	25. Was case referred to medical				28. Place of Dee	th (Check only on	e)			
Physician: r this certific real director,	10 E	examiner?	spital:	2 ☐ ER/Outpatien	t 3 DOA OI	her .	oma 5□ Rasida		ar (Specify)		
Attending Ph or deeth. octor: After thi by the funeral		27 Number of Death 1 ☑ Natural 5 ☐ Panding 2 ☐ Accidant Invastigation	28a. Data of Injury (Month, Dey Year	28b. Tima of Injury	Wo	iry at ork?] Yas 2 ☐ No	28d. Dascribe ho	ow injury occur	red		
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To the Hospital or Attending Phi within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral	edical (29e. Certiflar (Check only one) 1 ✓ Certifying Physic 2 ☐ Medicat Examine	clan: To the best of my ler: On the basis of axam end mennar stated.	knowledga, daath ination and/or inv	occurred at tha track	ime, data and place, opinion, daath occur	end due to the cred at tha tima, d	ausa(s) and me ata and placa,	ennar es sta and dua to l	itad. tha cause(s)	
Vithii To th comp	×	29b. Signatura and time of certifier	A	140	29c. Lican	sa number	~ /2	9d. Data signe	d (Month, D	ay, Year)	
6		30. Nema and address of person who com	MAD	XILLU	sly (0-24	535	4	1281	97	
(2)				d Branch		Clinton,	Marylar	nd 2073	5	/	
St. Regist	ate rar	Laxmi Berwa, M.D. 31. Data filed (Month, Day, Year) 30 1997	32 Registrar's Si	onatura	t£						

DHMH 16 Rev 6/95



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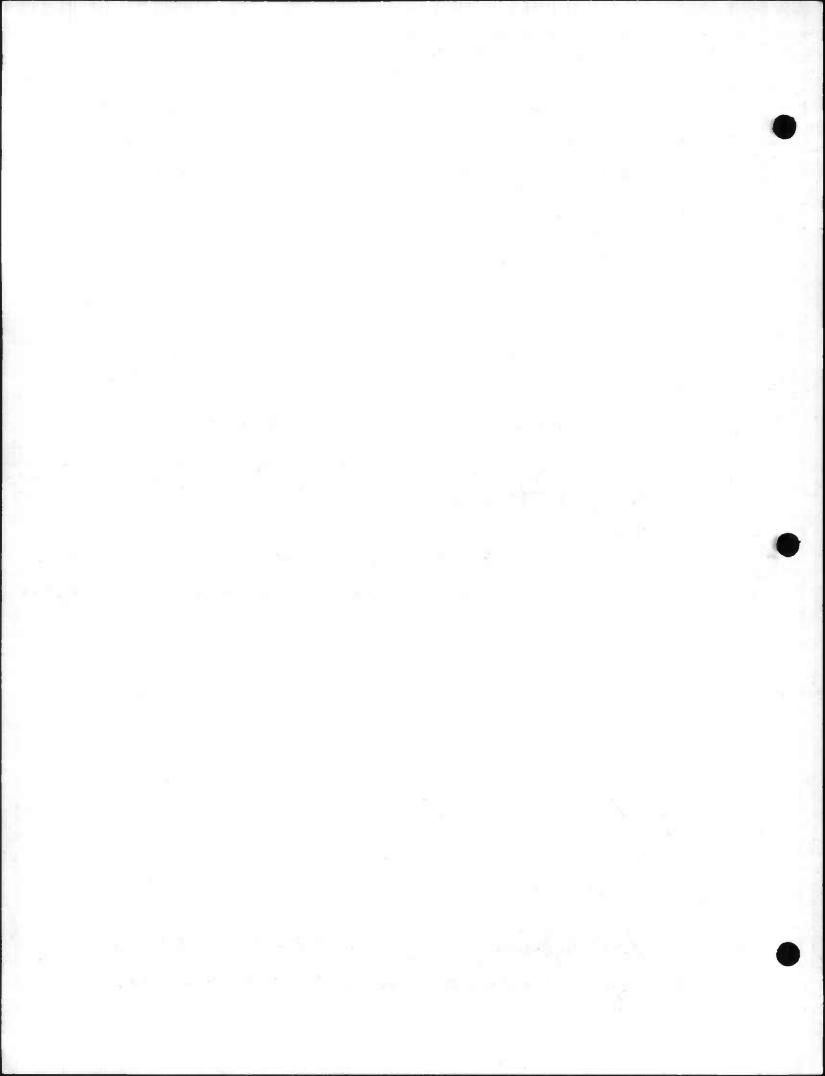
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth **Physician** 4a. Fecility Neme (If not inditation, give street end number) 12:30 AM 26,1997 Di! /Medical 4b, City, Town, or Location of Deeth 4c. County of Deeth Examiner | COLUMBULA
| HUnder 1 Year | HUnder 24 Hrs. | 8. Dete of Birth (Month, Dey, Year)
| Oct. 12, 19 Howard Howard County General Hospital 9. Birthplece (State or Foreign Country) 1916 New York 5 Social Security Number 6 Sex 7. Age (In yrs. lest birthdey) **Funeral** 1⊠M 2□ F Months Yrs. 80 Director 065-14-6254 Usuel Residence of Decedan the Meryland 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits mast be notified at 1 ☐ Yes 2 ☑ No MD Director Silver Spring Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 12129 Cliftondale 20904 USA Funerai death 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No If Yaa, Giva Yeer or Detas: 1943-45 than "natural", or items: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, atc. 11. Meritai Stetus permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examine. 1 ☐ Never Married 2 ☑ Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation
(Give kind of work dona during most of working
life. DO NOT use retired) Entertai 16b. Kind of Business/Industry Small Business/ Elemantary/Secondary (0-12) College (1-4or 5+) Entertainer Adminstration/Entertain Small Business Analyst 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Hazel C. Bowman Perry V. Vedder, Sr. 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 12129 Cliftondale, Silver Spring, MD Bonnie W. Vedder 20e. Method of Disposition 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burlel 2 ☑ Cremation 3 ☐ Removel from Steta 4 ☐ Donetion 5 ☐ Other (Specify) 5/2/97 Metropolitan Crematory Alexandria, VA 21. Signatura of Funaral Service Licensee 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete intervel Betw Onset and Death **Physician** /Medical immediate Cause (Fine) disaesa or condition resulting in deeth) Examiner 1.500 that the death certificate be executed physician and the burial-trensit Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Causa (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or es a consequence of): 98 use ŏ signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, by 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Wes an autopsy performed? Completed hes certificate 1 Yas 2 No or Attending Physician: effer death. Director: After this certific 25. Wes cese referred to medical examiner? Be 28. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 1 Yes ≥ No npatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28e. Dete of Injury (Month, Dev Year) 28c. Injury at Work? Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Spacify) 4 Homicide 24 hours e Hospital 29e. Cartifiar 🗷 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and dua to the cause(s) end menner stated. within 2 To the 29b. Signature and title 29c. Licensa number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) JERRY I LEWIS, MD 11055 31. Date filed (Month, Dey, Year) 32. Registrera Spratura State 0 1 1997 Registrar

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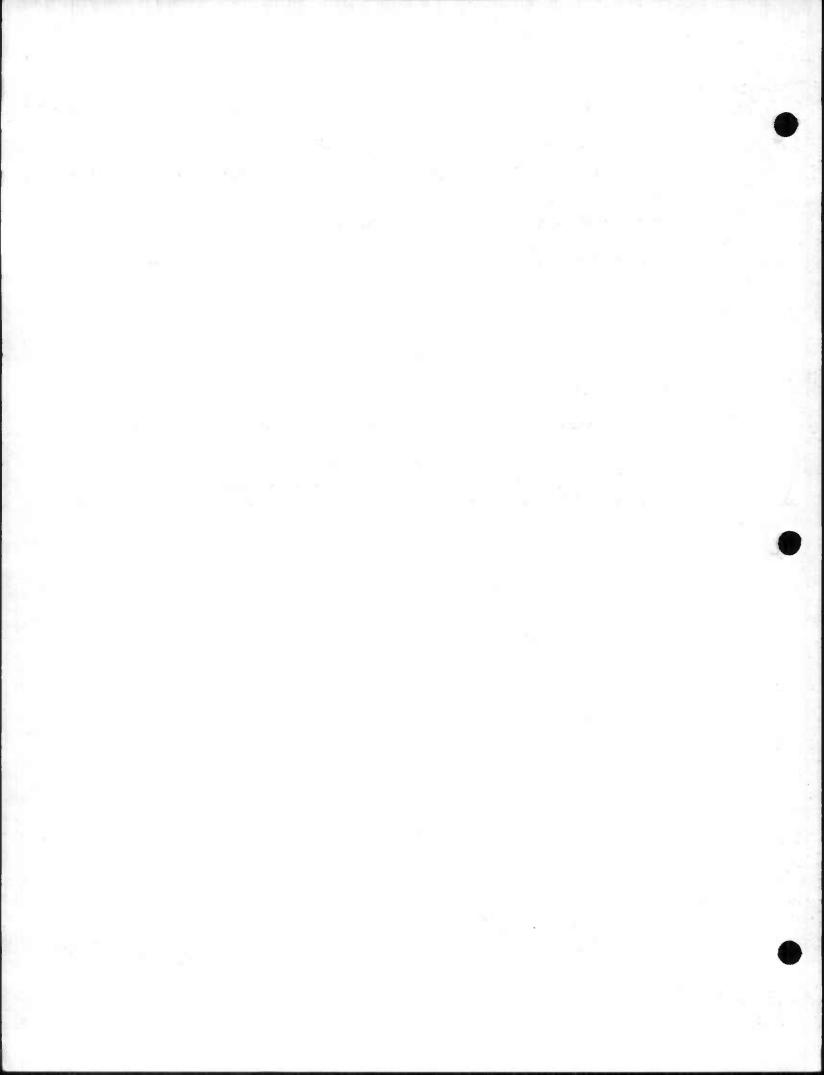
Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of	iviaryiano / I		riment of F	leaith and N Death	rental H	ygiene Reg. No.	97	14907
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			Suburban Hospital				Killed - A.V.	Bethesd			tgome	-
80	Funeral Director		5. Social Security Number 6. Se 577-78-5775 Usuel Residence of Decedent	X ∂M 2□F	Age (In yrs. lest bi	Yrs.	If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.				
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	with the Marylen a or 28a-f show	to	Maryland Montgome:	су	Pote	omac						1 ☐ Yes 2€ No
	r 286	Director	10e. Street end Number				10f. Zip Code			10g. Citizen o	of Whet Cou	ntry?
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	deep	Funeral	11. Maritel Stetus	12. Wes Decede	ent Ever in U,S.	13. W		lispenic Origin? (Sp en, Mexicen, Puerto	ecify Yes or N		ace - Ameri	can Indien,
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2121	within ene.	Completed	Eiementary/Secondary (0-12)	Coilege (1-4	or 5+)		nist ONOT use retired nist	during most of work	ing	Hosp	ital	
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lan	2 sho and I is ma		19e. Informent's Neme/Reletionship (T	rpe, Print)	198	b. Mailing	Address (Street	end Number or Run	el Route Num	ber, City or Tow	vn, Stete, Zij	o Code)
	Health Am 27 inther tr		Lata B. Vyas/ Wife	2	92	201 (Orchard	Brook Dri	ve, Po	_	-	
Ore	00		20e. Method of Disposition 1 ☐ Burial 2 ☒ Cremetion 3 ☐ I	Removel from Sta	20b. Plece o cemete	of Disposi ary, creme	ition (Neme of etory or other plea	May 2,	1897	20c. Location	n - City or To	own, State
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Baltimore,	permit. Pag Department Important: If any Injury o		21. Signature of Funeral Service Licens	1	M00689	Be	thesda-C	^{ss of Fecility} Rob hevy Chas Maryland	e, Inc	. 7557	ey Fu Wisco	neral Home/ nsin Avenue
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89	death certificete be executed e ettending physician and wd for use as the burial-transit	edical	resulting in deeth) Lest		Due to (or es e	conseque	ence of):				1	
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		ii o	27. Menerer of Deeth 1 ☑ Naturel 5 ☐ Pending	28e. Dete of I (Month,		Time of Injury	28c. Injur Wor	y et k?	28d. Describe	how injury occ	urred	
Sio	Attanding or death.	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2 □ No				
Division	E Sitt	Certification:	4 ☐ Homicide determined	28e. Plece of building,	Injury - At home, fa etc. (Specify)	arm, stree	et, fectory, office			(Street end Nui own, Stete)	m <i>ber</i> or Run	el Route Number,
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	To the Hospital or within 24 hours after To the Funeral Director completely filled in	edical	29a. Certifier (Check only one) 1 Cartifying Phy 2 Medical Exami	ner: On the basis	s of examinetion en	nd/or Inve	stigetion, in my o	pinion, deeth occurr	ed et the time	dete end plec	e, end due t	o the ceuse(s)
		Σ	29b. Signeture and title of certifier	/			29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)
	30		1/ hay	ine			117	レムケグ		5///	147	
			30. Name end eddress of person who co					005 5			001-	
			Michael Kenner, M	1000	77	ın A	venue, #	925, Chev	y Chas	e, MD 2	0815	
	Sta Registr		31. Dete filed (Month, Dey, Year) MAY 0 2 1997	32. Regi	strer's Signature	Pando	œ_					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mi	arylariu		tificate of	Death		Reg. No.	97	14908		
	Dharatai		1. Decedent's Name (First, Middle, La	ist)					2. Date of Dec	ath	Vana	3. Time of Death		
	Physici /Medic		Edith Ramsay	White	omb				April	30,	1997	2:36 PM		
	Examir		4a. Facility Name (If not institution, gir	ve street end number)				4b. City, Town, or L	ocation of Death	4c. Count	y of Death			
L			Manor Care-Wh					Silver Sp			gomery			
	Funeral			Sex 7. Ag 1 □ M 2 1 ☑ F	e (In yrs. lest	birthday) _ Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, De	h y, Year)		ace (Stete or Foreign		
	Director		220-44-7711 Usuel Residence of Decedent		82	IIIS.			Mar.7,	1915	Washin	ngton, D.C.		
	dand		10a. Stete 10b. County		10c. City, T	own or Loc	ation				10	d. Inside City Limits		
	Man	io	Maryland Montgom	erv	Si	1ver	Spring					1 ☐ Yes 2 ☑ No		
	or 284	Director	10e. Street and Number			TVOL	10f. Zip Code			10g. Citizen of	What Counti	ry?		
	th will		14921 Pennfield	Circle			209	906		U.S.A				
	r dea	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U,S.	13. W		dispenic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		ce - America			
20	or h		1 Never Married 2 Married	1 ☐ Yes 2 ☑ N	No		☐ Yes 21 No		7110211, 0101,	Specif				
21215-0020	72 hours efter death with the Maryland "naturel", or Herrs 23a or 28a-f show sideal Examiner must be notified at	d by	3 X Widowed 4 □ Divorced	Yeer or Dates:							Whit			
15	na 72	lete	15. Decedent's E (Specify only highest gr	ducation ede completed)		(Give k	ent's Usual Occus ind of work done O NOT use retire	during most of work d)	ring	16b. Kind of B	usiness/Indu	ustry		
212	be filed within 72 ho tiel Hygiene. d other then "netur event, tre Moulca!	Completed	Elementary/Secondery (0-12)	College (1-4or 5		ile C		-,		Feder	al Gov	vernment		
p	e filed of the other to	BeC	17. Father's Name (First, Middle, Last)		TIC (JETR	18. Mother's Nam	e (First, Middle,			CITIMOTIC		
Maryland		To B	James Ramsay					Agnes	Scott					
lan	d 2 should th end Mer 7 le marke traumatic		19a. Informent's Neme/Relationship	Type, Print)		19b. Meiling	Address (Street	end Number or Ru	rel Route Numbe	er, City or Town	, State, Zip (Code) 20906		
			Bonnie J. Hummer		1	4921	Pennfie:	ld Circle		r Sprin				
Baltimore,	permit. Peges 1 end Department of Heelth Important: If Item 27 any Injury or other to		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place ceme	a of Dispos etery, cremi	itlon (Neme of etory or other ple	ce)	Dete	20c. Location	- City or Tow	m, State		
Ë	. Peges ment of I		4 ☐ Donation 5 ☐ Other (Special		Metr	opoli	tan Crem	natory	5/1/97 A	lexandi	ria,Vi	rginia		
Sal	permit. Pe Departmer Important: any Injury once.		4 Donation 5 Other (Specify) Metropolitan Crematory 5/1/97 Alexandria, Virginia 21. Signature of Fineral Service Licanus 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc.											
_	00 = 0 0		Mober ?	Kamsi	ey	500	Univer	sity Blvd	W. Si	l.Spr.		and 20901		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each	deeth. [Do not enter	r the mode of dyir	ng, such as cardiac	or respiretory er	rest,	1	Approximate fnterval Between		
	Physician /Medicai		Immediate Course (Final	Λ		- 0	2 [1.5				Onset and Death		
	Examiner		Immediate Ceuse (Final disease or condition resulting in death)	a.///YOC	and	ial	huje	and us	1			Judday		
	711	ē		116	Due to (or es	a consequ	ence of):					Guddoy Years		
	od dansit	Examiner	Securetially list and disease	b. 11/12	Due to (or as	HON	0000,000				<u> </u>	years		
ó	e xec		Sequentielly list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events	v 8tro	Lo	a consequ	onco orj.				192	Vegan		
68760,	ificate be executed g physicien and as the buriel-transit	edicai	Cause (Disease or Injury thet Initiated events resulting In deeth) Last	c. /	Due to (or es	a conseque	ence of):					12000		
	ng ph as ti		resulting in deetil) Last	50										
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	the e	/sic	Part II. Other signiffcant conditions	contributing to death bu	ut not resultin	g in the und	derlying cause giv	ven in Part f.	23b. Dld t	obacco use co	entributa to f	the cause of death?		
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ā	n: Th ficate or, pa		25. Was case referred to medical						101	/	10	Yes 2□ No		
	Physician: rthis certific ral director,	To Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2 TEB	/Outpetient	3 DOA Oth	26. Place of Deet			(Cit-)			
O	Phy orthis		27. Manner of Death	28e. Date of Injur	y 28	b. Time of	28c. Injui	1	ome 5 Resid					
0	ath. r: Afte e fun	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, De)	Year)	Injury		rk? Yes 2 □ No						
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Ö	tal or A	Cer	* E 110/110/00	boliding, etc	. (Specify)				Chy of You	m, Steley				
	To the Hospital or Attending Physician: The I within 24 Journs effect death. To the Funeral Director: After this certificate he completely filled in by the Iuneral director, page	edicai	(Check only 2 Madical Exar	yalcian: To the best on ninar: On the basis of	f my knowled	dge, death o	occurred at the tire	me, date and place,	end due to the o	ceuse(s) and m	anner as sta	ted.		
	within 2. To the F Complet	Med	oney	and manner sta	ted.	011201 11110								
	2 2	-	29b. Signeture end title of certifier	1 - 1	4		29c. Licens	e number		29d. Date signe	ia (Month, D	ay, Y68f)		
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			30. Neme and address of person who	20.1	0		rint)	- الذم	. <	1. 1	2-0	107-		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ir's Signeture	1	H Z	Silve	Spring	100	0 00			
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State of Maryland / Department of Health and Mental Hygiene

29d. Dala signed (Month, Day, Year)

April 24, 1997

14909

Physician
/Medical Examiner

3. Tima of Death 7:20P.

Funeral Director

the Manylend

permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Marylen Department of Health end Mental Hygiene. Important: If Item 27 is merked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Mexical Examiner must be inclified at once.

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

Physician /Medical Examiner

sician end buriel-transit The law requires that the death certificate be executed physician s the buriel signed by the ette should s page 2 hes certificete Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certification by the funeral director. • Funeral

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death April 23, 1997 **Blanche** Maude Wood 4a. Facility Nama (If not Institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death 4713 Olympia Avenue Beltsville Prince George's 5. Social Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Sept. 14, 1908 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign Days Hours 1 M ZOXF Washington, D.C. Yrs. 216-74-0509 88 Usual Rasidance of Dacedani 10b. County 10c. City, Town or Location 10d. insida City Limits Maryland Prince George's 1 Yas 2 700 Director Beltsville 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 4713 Olympia Avenue 20705 United States Funeral 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 1 ☐ Yas ŽŽNo If Yas, Giva Yaar or Datas: 1 □ Navar Marriad 2 □ Marriad 1 ☐ Yas > No Specify: White þ Specify: XX Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentery/Secondary (0-12) Collega (1-4or 5+) Housewife Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumema) Be William, Kesterson Susan Kidwell 19e. Intormant's Name/Relationship (Type, Print) 19b. Melling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) Frank M. Wood, Jr. 8-C Ridge Road Greenbelt, Maryland (son) 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Burlai 2 Cramation 3 Ramoval from State 4 ☐ Donalion 5 ☐ Other (Specify) 4/26/1997 Brentwood, Maryland Fort Lincoln Cemetery 21. Signatura of Funaral Sarvice License 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enlar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata inlarval Batweer Onset and Deat Immediata Causa (Final disaesa or condition rasulting In death) Cerebrovascular Accident Dua to (or as a consequence ot) Examiner ooxemia Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Ceusa (Disaasa or Injury that initiated avants rasulting in daath) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yes 2 ☐ No 24a. Wes an autopsy performed?

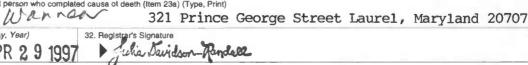
Physician/Medicai 23b. Did tobacco use contributa to the causa of death? 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to complation of causa of death? Completed 1 Yas XX No 1 Yas 2XNo 25. Was casa rafarrad to medical axaminer? Be 26. Placa of Death (Check only one) Hospitel: Othar: 4 Nursing Homa XX Rasidance 8 Othar (Specify) 1 ☐ Yas 2XXVo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Wetural 28d. Dascribe how Injury occurred 28b. Tima of 28e. Deta of Injury (Month, Day Year) 28c. Injury at Work? 5 Panding 1 Yas 2000 invastigation 2 Accidant 8 Could not be determined 3 Sulcida 28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Spacify) Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida 29a, Certifier XX Certifying Physician: To the best of my knowledge, death occurred at the tima, date and placa, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

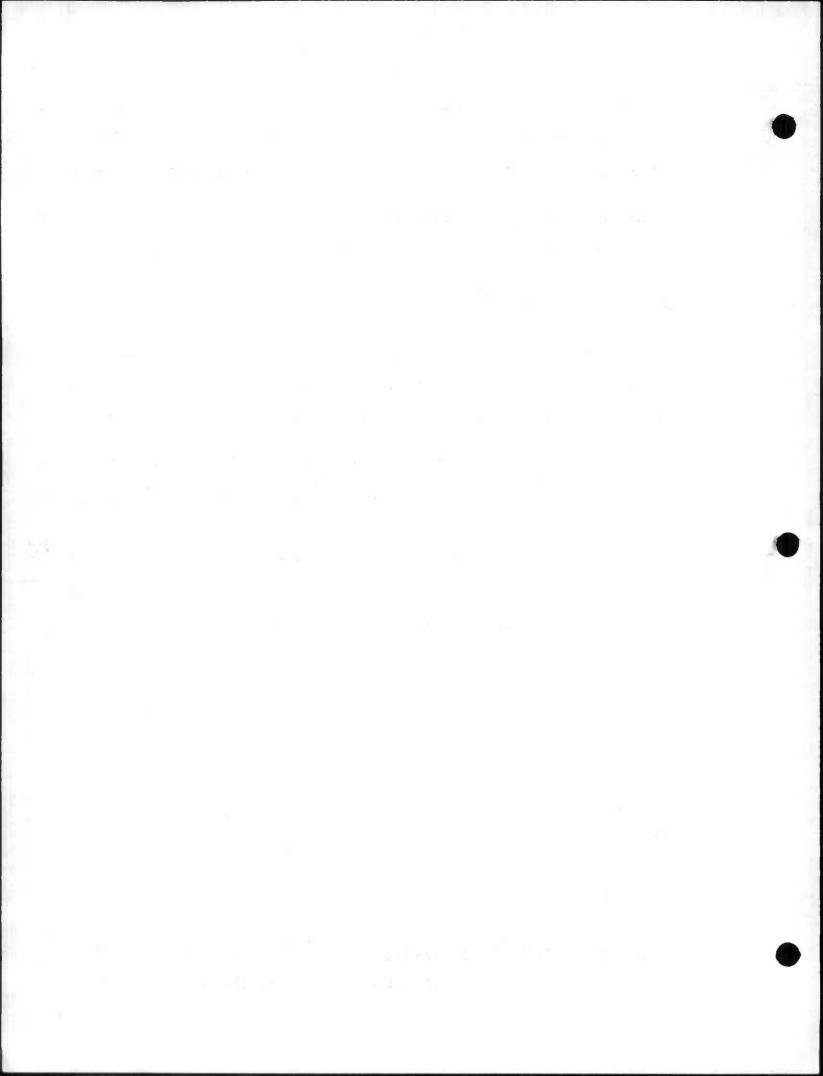
State Registrar 31. Data tilad (Month, Day, Year)

30. Name, and addrass of person who complated causa of deeth (Item 23a) (Type, Print)

29b. Signatura and titla of cartitia

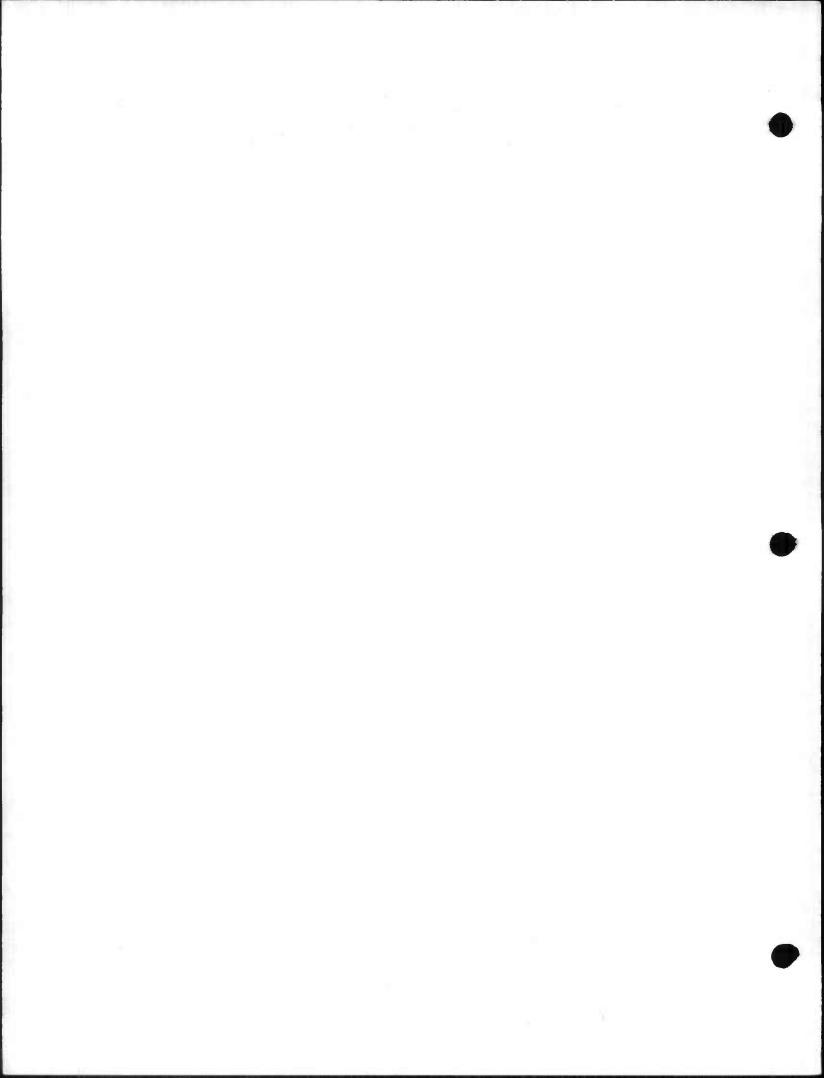


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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Maryland /	Certificate of			ene 9	7	4910
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	Examir Funeral Director		5. Social Security Number 6. Sax	Yealth Care	Imetzeko H Rd. iirthday) If Undar 1 Ya Months Day	ar If Undar 24 Hrs.	8. Data of Birth (Month, Day, May 30,	Year)	e Geor	ca (Stata or Foraign
	/lend		Usual Rasidance of Decedant 10a. Stata 10b. County	10c. City, To	wn or Location					. Insida City Limits
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	heath me 23	erai	1818 - 24th Stree	12. Was Decedant Evar in U.S.	13. Was Decedant of		ecify Yas or No-	United 14. Race	State - Amarican	
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Baltir	permit. Page Department of Important: If any Injury or once.		21. Signature of Punetal Sewitte Usera	Marie		drass of Facility Juneral Ser	vice, In	ıc.		
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	Mospital or 24 hours afte Funeral Dir etaly filled in	edical	29a. Certifier Check only one) Certifying Phys	ician: To the best of my knowledger: On the basis of examination a and mannar stated.	ge, death occurred at the nd/or invastigation, in <i>m</i>	time, date and place, y opinion, daath occur	and due to the ca red at tha tima, da	use(s) and ma ata and place, a	nnar as state and due to th	ed. ie cause(s)
	vithin 2 To the comple	Me	29b. Signatura and little of contiller	and maintai stateg.	29c. Lice	ansa nu <i>m</i> ber	25	9d. Data signed	d (Month, Da	y, Year)
	6		Hew	2.	DI	9609.	1	1.26-	97.	
			30. Nama and address of person who co	npleted causa of daath (Item 23a	(Type, Print) RRY STA	DEET M	T Par	. 1	109	717
	Sta	te	31. Data filed (Month, Day, Year)	32. Ragistri 's Signatura	6	CEI, M	1. puply	er 1	y de	111)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month PRIL HENRY WANG 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months t € M 2 F Vrs 220-94-4912 82 March 12,1915 China Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1021 Welsh Drive U.S.A. 14. Race - American Indian, Black, White, etc. 20852 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Maritai Status 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☐ Divorcad Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bank Executive Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sung-You Wang Chen Chuen-Mei 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 19a. Informent's Name/Relationship (Type, Print) Shuen-Hwa Wang 527 Congressional Lane #220 Rockville, Maryland 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 4/29/97 Silver Spring, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 18 500 University Blvd., W., Sil. Spr., Maryland 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each me Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting to death) disease cars Due to (or as a consequenca of) TROKE Due to (or as a consequence of): HEART (ONGESTIVE Due to (or as a consequence of) 23b. Did tobacco use contribute to the causa of death?

Physician /Medical Examiner

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certificate

funeral c

filled in by

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice

Division of Vital Records, P.O. Box 68760.

Examiner

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Certification:

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permit. Peges 1 and 2 should be file Department of Health and Mentel Hy Important: If flem 27 te marked other any Injury or other traumatic event, panes.

Physician

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10a. State

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tem 27 is marked other than "natural", or frems 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at

e filed within 72 hours efter of Hygiene.

Baltimore, Maryland 21215-0020

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i.

1 Yee 2 No 3 Probably 4 Unknown

24a. Was an autopsy parformed?

24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1□ Yes 22 No 27. Menger of Death

5 Pending

6 Could not be determined

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28b. Time of investigation

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Universty Blad W. Wheatone MD 20902

2 No

28d. Describe how injury occurred

26. Place of Deeth (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Natural

2 Accident

3 ☐ Suicide

4 Homicide

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(a) and manner aa stated. 2 Medical Examinar: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year)

MA

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30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) MP 1721

Hospital:

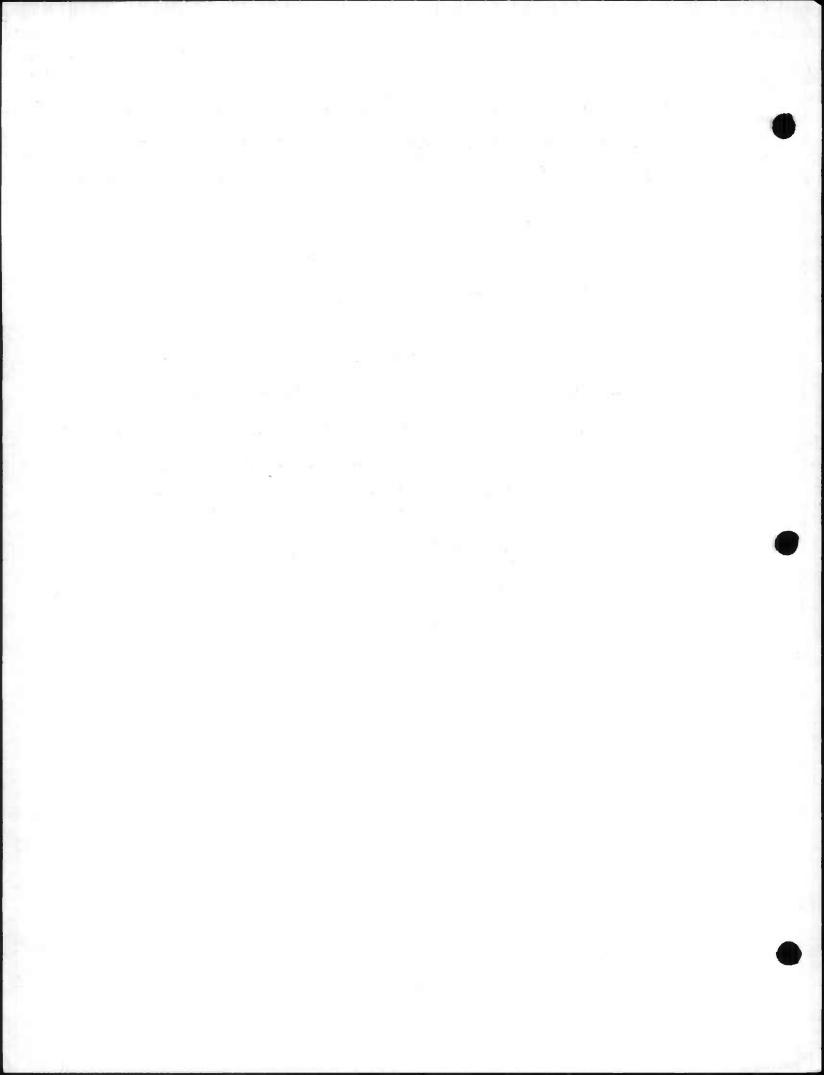
31. Dete filed (Month, Dey, Yeer)

APR 2

32. Registrar's Signature Felia Davidson

Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middia, Last) 2. Data of Daath Month -45 James Wise 5 april 23 4a. Facility Nema (If not institution, giva straat and number) 4b. City, Town, or Location of Deeth 4c. County of Death 01ney Montgomery General Hospital Montgomery 5. Sociel Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Deta of Birth (Month, Day, Year) 1⊠M 2□F Months Days Hours Yrs. 245-12-8964 74 Dec. 3, 1922 NC Usual Rasidence of Dacedent 10a, State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☑ No Montgomery Rockville 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? 4103 Canterbury Terrace 20853 USA 12. Was Decadant Evar in U,S. Armed Forces? 1 (X)Yas 2 (☐) No WW II IYYes, Giva Year or Datas: Korea Was Dacedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritel Status 14. Race - Amarican Indien Black, Whita, atc. 1 ☐ Naver Merried 2 ☑ Married 1 ☐ Yas 2 ☑ No Specify: Specify: 3 Widowad 4 Divorced White 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elamentary/Sacondary (0-12) College (1-4or 5+) Research Technician Federal Government 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Charles Franklin Wise Maggie GAskey 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Anneliese G. Wise 4103 Canterbury Terrace, Rockville, MD 20853 20a. Method of Disposition Placa of Disposition (Name of cematary, cramatory or other plece) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 4/26/97 Rockville, MD 21. Signature of Funeral Sarvice Licensaa 22. Name end Addrass of Fecility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23e. Parli. Entar the disaasa, or complications that ceused the daath. Do not entar tha moda of dying, such as cerdiac or respiretory errest, shock, or haart failura. List only one causa on each line. Spring, MD 20901 Approximate Interval Batwaan Onsat and Death Cardio my o pat Immediata Causa (Final diseese or condition resulting in death) Due to (or as a consequence of): Dua to (or as a consequence of) Dua to (or as e consequance of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ne al. tes 24b. Wara autopsy findings evelleble prior to complation of causa of daath? 24a. Was an autopsy performed? 2.3No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was cesa rafarred to medice! 26. Placa of Daath (Check only ona)

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Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

7 is marked other traumatic event, 1

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To the Hospital o within 24 hours af To the Funeral Di completely filled is

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Certification:

Medical

21215-0020

Baltimore, Maryland

Box 68760,

P.O.

Division of Vital Records,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Hospital: 1 ☐ Inpatiant 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury et Work? 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of

1 Naturai 5 Panding Invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicida 6 Could not be datermined 28a. Place of Injury - At homa, farm, straat, fectory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State)

29a. Cartifier

1 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar es stated.

Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, end due to tha causa(s) and menner stated. (Check only one) 29b. Signetura and title of certifie

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29c. License number 29d. Date signed (Month, Day, Year)

30. Nama and addrass of person who complated causa of death (item 23e) (Type, Print)

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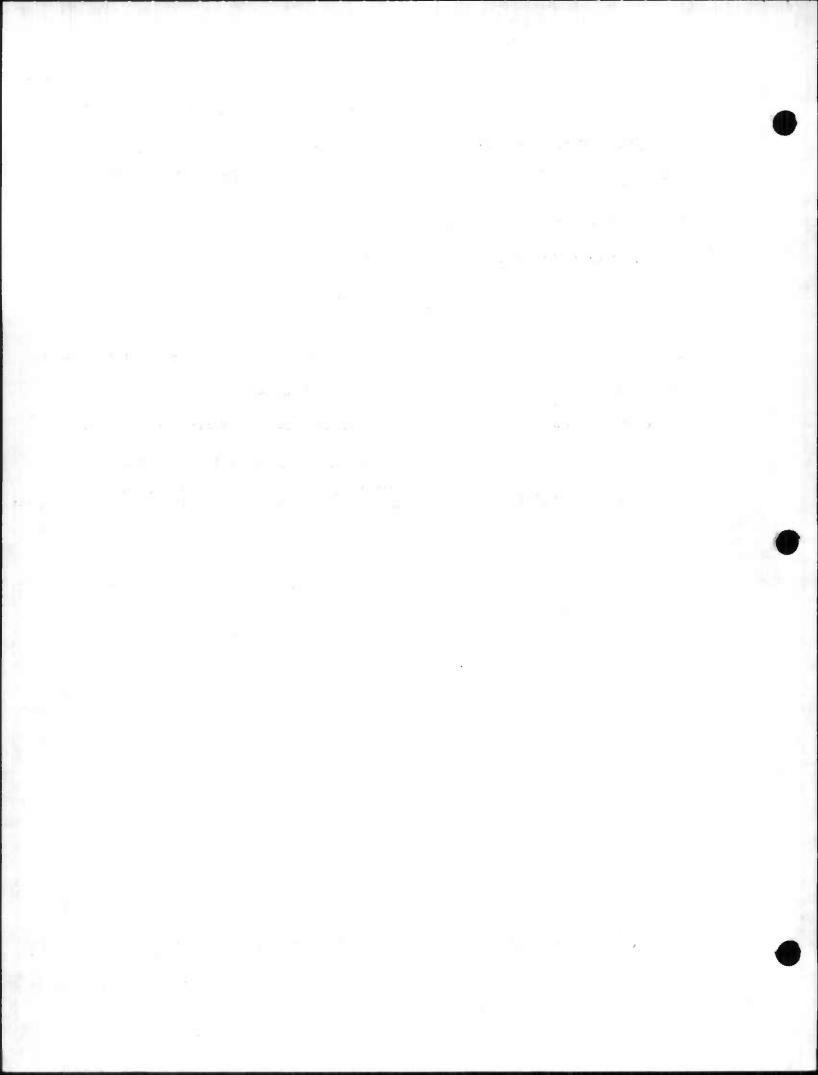
State Registrar

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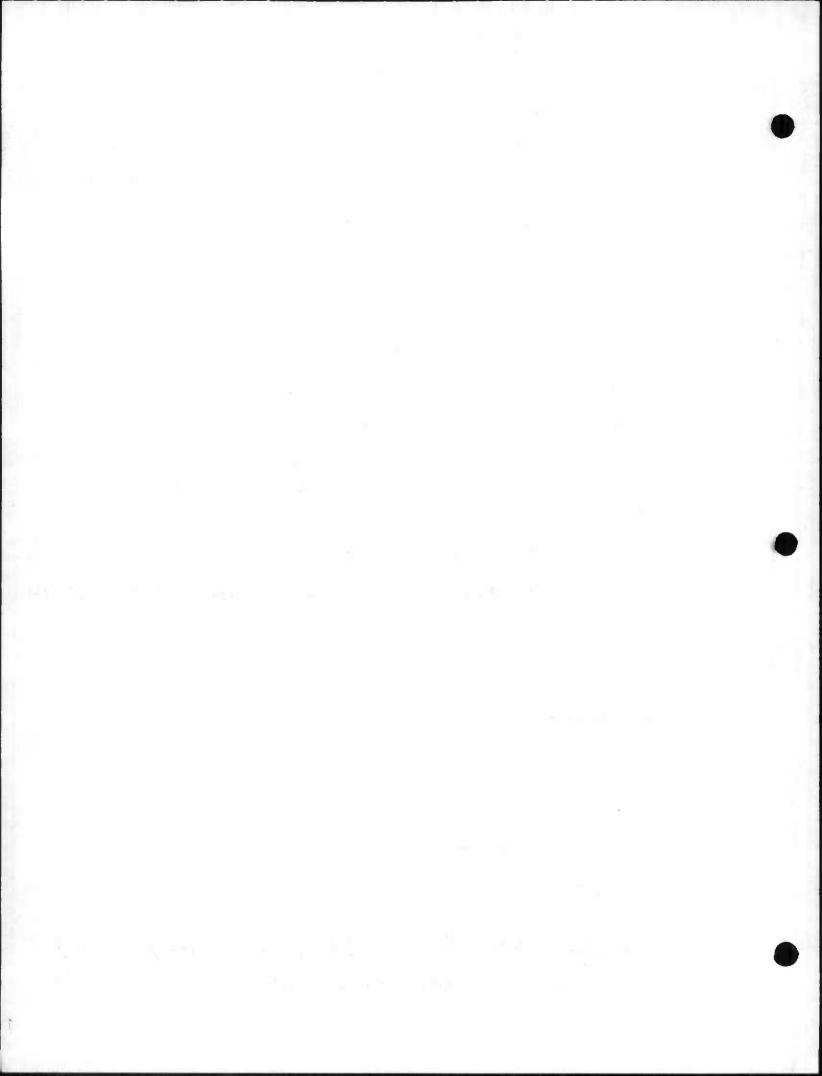
32. Registrar's Signatura Philip Devidon APR 2 8 1997

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						iai yiai iu 7		tificate of	Death		Reg. No.	7	4913	
	Physic	ian	Decedent's Neme (First, Middle, Last)								Dete of Deeth Month Dey Yeer 3. Time of Death			
-8	/Medi			Margaret E. Wagner						May 3,	1997		12:01 am	
	Examlı	ner								Location of Deeth	on of Deeth 4c. County of Deeth			
L			Greenbelt Nursing & Rehab. Center 5. Sociel Security Number 6. Sex 7. Age (in vrs. lest birthday) If Under 1						Greenbel					
	Funeral Director		5. Sociel Security Number 577-07-0710				If Under 24 Hrs. Hours Min.	(Month, Da)	8. Dete of Birth (Month, Day, Year) May 26, 1916 9. Birthplece (State or Foreign Country) Washington DC					
Baltimore, Maryland 21215-0020	how how		Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Local					cation 10d. Inside City Limits						
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		Ta .	6800 40th Av	enue				20782			USA			
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			10 Librarian						County Government					
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			19e. Informant's Neme/Rel	ationship (7	ype, Print)	19	b. Mailing	Address (Street	end Number or Ru	iral Route Numbe	r, City or Town	, State, Zip C	code)	
	1 end 2 Health em 27 I		Ronald Raffo						mb Road,	Severna	Park,	MD 2	1146	
	or oth		20e. Mathod of Disposition 1 Buriel 2 ☐ Creme	ation 3 □	Removel from State	20b. Plece camet	of Dispos ery, creme	ition (Name of etory or other plac	ce)	Dete	20c. Location	- City or Tow	n, Stete	
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Ball	permit. Pages 1 end Department of Health Important: If Item 27 eny injury or other tr once.		21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 2090											
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Division of Vital Records, P.O. B		by Physician/N	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.							23b. Did tobacco use contributa to the cause of death?				
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	Hospital or Attending Physician: Euk hours effet death. Fureral Director: After this certific tiely filled in by the funeral director.		25. Was case referred to m											
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	Sta		31. Dete filed (Month, Dey,		32. Registr	's Signature	Inn a	andone.						
	Registr	ar	MAY	Ub	1997	The same of the								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death Month SAMUEL HENRY WEDDINGTON April 27 1997 11:05 pm 4a. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County oi Death Doctors Community Hospital Lanham 8. Data of Birth (Month, Day, Year) 2 h 4, 1922 Prince George's 6. Sex 10 M 2 ☐ F If Undar 1 Year If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Months Deys Hours 242-26-4714 75 Yrs. Concord, Usual Residanca of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 XYas 2 No Md. Prince Georges Landover 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? #202 20785 1/26 Bright Seat Rd. United States 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas ≥ 2 ②No if Yas, Giva Yaar or Dates: 11. Marital Stetus Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decadent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collaga (1-4or 5+) Laborer Private 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumame) Macgauger Weddington Bessie Stewart 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1726 Bright Seat Rd. #202 Landover, Md 20785 Wife Chelly Weddington 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burlal 2 □ Cramation 3 □ Removal from Stata Glenwood Cemetery 5-2-97 Washington, DC 4 ☐ Donetion 5 ☐ Othar (Specify) of Funeral Service Licet 22. Name end Addrass of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 20002 plications that caused the death. Do not enter tha mode of dying, such es cardiac or respiratory errest, one cause on each line. Part1. Entar tha disaase or shock, or haart failura. Approximata Intarvai Batw Onsat end Death Immadlata Causa (Final 3 milles disaase or condition rasulting in death) Sequantielly list conditions, if any, leading to Immadiate causa. Enter Undarlying Cause (Diseese or injury that initieted avants rasulting in daath) Last Due to (or as e consequence of): Dua to (or es e consequança of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 Probably 4 Nunknown 24a. Was an autopsy performed? Wara autopsy lindings aveilable prior to complation of causa of death? 1 Yes 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical 26. Placa of Death (Check only one) 1 Yas 2 No Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar (Specify) 1 Dippatiant 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

py

Completed

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Funeral

Director

nem 27 is marked other than "naturel", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be inclifted at

72 hours after death with the Meryland

filed within 7 I Hygiene.

permit. Pages 1 and 2 should be filed withit Department of Health and Mentel Hygiene. Important: If flem 27 is marked other than any injury or other traumests.

Baltimore, Maryland 21215-0020

P.O. Box 68760

Records,

Division of Vital

amuel Henry

Wedd, ngton

Examiner

Physician/Medical by Completed page 2 Be 2 Certification:

physician and s the burial-transit requires that the death certificate be executed signed by t hes certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica filled in by

Mødicai pletely State Registrar

29b. Signature and title of cartifiar

5 Pending Investigation

6 Could not ba dataminad

29c. License number

1 ☐ Yas 2 ☐ No

28c. Injury at Work?

12 Cartifying Physicien: To the best of my knowledge, death occurred at tha time, date and plece, end dua to tha causa(s) and menner as steted.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and mannar stated. 29d. Date signed (Month, Day, Yaar)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

28d. Dascribe how injury occurred

Road, Landover MD

30. Nama and eddrass of person who complated cause of death (Itam 23a) (Type, Print) -IPISHRES

NAYAK 6501 Landover

32. Registrer's Signature

28b. Time of

28a. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify)

31. Data filed (Month, Day, Year) 02

27. Mennar of Deeth

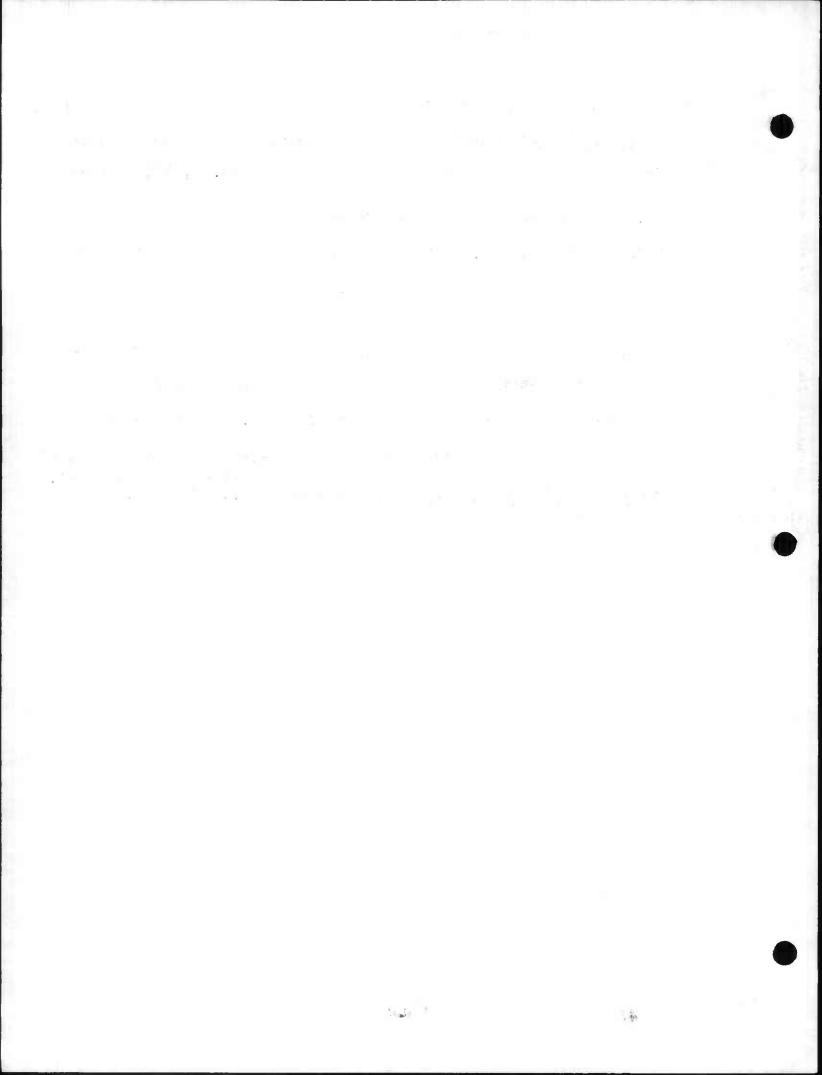
1 Natural

2 Accidant

4 - Homicide

3 ☐ Sulcida

29a. Cartifier



State of Maryland / Department of Health and Mental Hygiene 14915 Certificate of Death 1. Decedant's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth **Physician** Month WOOLLEYHAN RAYMOND MARSHALL 1997 862 /Medical 4b. City, Town, or Location of De 4a. Fecility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Ceci1 Union Hospital of Cecil County Elkton If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Deys Hours Min. Dews 1950 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foraign Country) 1**⊠** M 2□ F Months 46 212-74-9205 Yrs. Delaware Usuei Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Chesapeake City Cecil Maryland 1 ☐ Yas 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21915 24 Lamborn Lane Was Decedent of Hispenic Origin? (Spacify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decadant Evar in U,S. Armed Forces? 14. Rece - American Indian, Bieck, Whita, etc. 11. Merital Status 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest greda completed) Elamantery/Secondery (0-12) College (1-4or 5+) Disabled Mentally Handicapped 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Nowland Griffin Woolleyhan Jeanette Elizabeth Barlow 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Richard Woolleyhan (bro) 24 Lamborn Lane Chesapeake City, MD. 21915 20b. Plece of Disposition (Neme of cemetery, cramatory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 M Cremetion 3 ☐ Ramovel from State 5-5-97 4 ☐ Donetion 5 ☐ Other (Specify) Capitol Crematory Dover, Delaware 21. Signature of Funeral Service Litter Calena Funeral Home of Stephen Schaech M00510 Galena, MD. 21635 Box 235 disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, feilure. List only one cause on each line. Onset and Death Immediate Cause (Final 1/2 how diseesa or condition resulting in deeth) Examiner gastroen Sequentially list conditions, if eny, leading to Immediate cause. Entar Undarlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Physician/Medical Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown by 24b. Were autopsy findings evelleble prior to Completed 24e. Wes en eutopsy performed? completion of cause of deeth? 1 ☐ Yes 2 TONO 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Pleca of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending invastigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Piaca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Straet end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and manner stetad. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. Licensa number May 2,199

Elkton, MD.

21921

State Registrar

30. Name end eddress of person

31. Dete fited (Month, Dey, Year)

MAY 0 5 1997

ara

who completed cause of death (Item 23e) (Type, Print)

32. Registrer's Signature

Union

herland

while Dedidoon

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic event, he Medical Examiner must be notified at

the Maryland

deeth

reges 1 and 2 should be filed within 72 hours eiter and Mentel Hygiene.

Etf flam 27 is marked other than "natural" and or other transment.

Peges 1 ament of He

permit. Pege Department of Important: If any injury or

Physician /Medical

Examiner

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signed by

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hes certificate

Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifica

To the Hospital of within 24 hours e To the Funeral C

page 2 should

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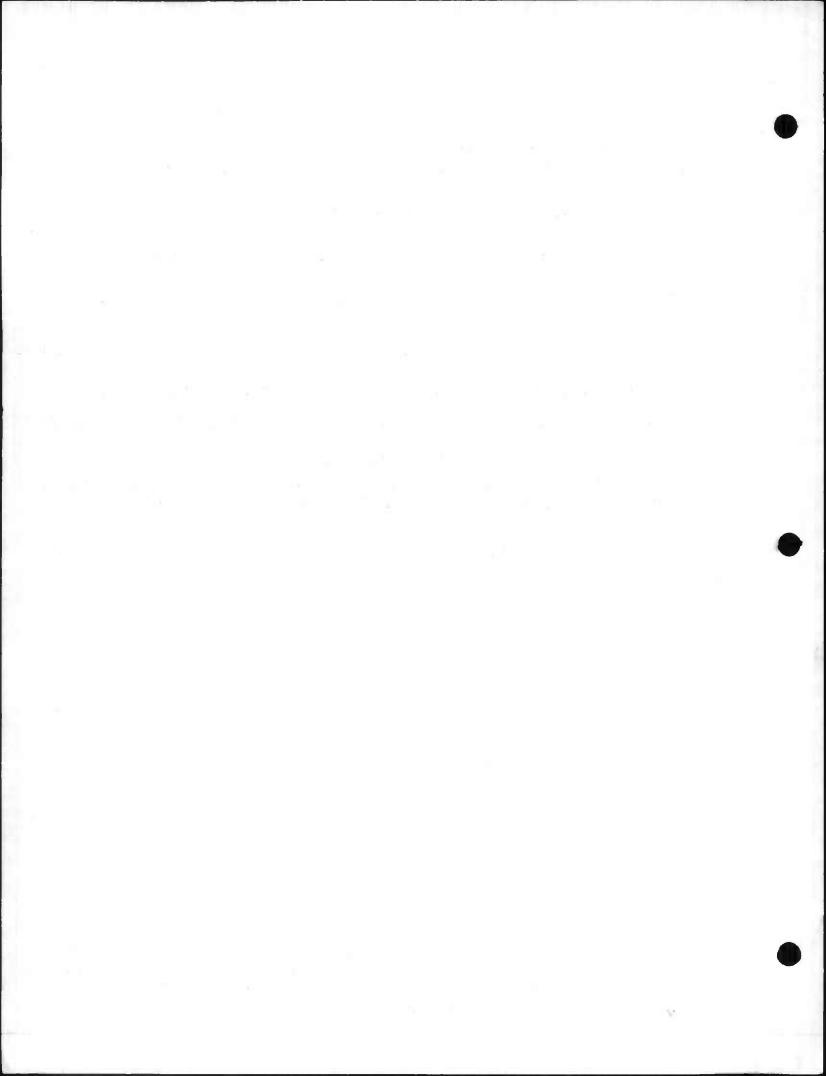
npletely

and physicien a

P.O. Box 68760.

Division of Vital Records.

Saltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene Item 8, 19a per FH Film G748 6-18-97 rja Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of the Dey Month **Physician** Yee APRIL 29, 1997 3:30PM MARTHA JANE WALTERS /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** PRINCE GEORGE'S UPPER MARLBORO 1025 DREXEL GATE LANE If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) 9. Birthplece (State or Foreign **Funeral** Hours 1 ☐ M 2**X** F Months Deys 183-32-7880 Yrs. Director JANUARY 1,1941 PENNSYLVANIA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. other than "natural", or items 23a or 28a-1 snow vent, the Medical Examiner roust be notitied at 1 X Yes 2 □ No Directo MARYLAND PRINCE GEORGE'S UPPER MARLBORO 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? 72 hours efter death with 1025 DREXEL GATE LANE 20774 UNITED STATES Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0020 Specify: BLACK 1 ☐ Yes 2 🛣 No Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementery/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSE WIFE i. Peges 1 and 2 should be filed w thent of Health and Mentel Hygle tant: If item 27 is marked other ti lury or other traumatic event, in Baltimore, Maryland 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be FRANCIS SHERROW MARGARET MELLINGER 2 19a Informent's Name/Relationship *(Type, Print)* AARON 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Peges 1 end 2:
Department of Heelth at
Important: If item 27 is
any injury or other trau 1025 DREXEL GATE LANE, UPPER MARLBORO, MARYLAND20774 AaRON E. WALTERS 20a. Method of Disposition
1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete 20b. Plece of Disposition (Name of carmetery, cremetory or other plece) 20c. Location - City or Town, State RIVERDALE BAPT.CH. CEM. 5/2/97 4 ☐ Donetion 5 ☐ Other (Specify) RIVERDALE, MARYLAND 21. Signeture of Funerel Servica Licensee 22. Name and Address of Fecility ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in deeth) METASTATIC LUNG CANCER 2 YEARS **Examiner** Due to (or es a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lesf Due to (or es e consequença of): Division of Vital Records, P.O. Box 68760, ding physiclan Physician/Medical Due to (or as e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by t should be detect 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 2 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical Be 26. Piece of Death (Check only one) exeminer? 1 Yes 25 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 Other: 4 Nursing Home 5 A Residence 6 Other (Specify) After this 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Medical Certification: 28b. Time of 5 Pending Investigation Neturel death. 1 Yes 2 🗆 No 2 Accident Director: 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital continuous offer To the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Programment of the Funeral Progra 4 Homicide 29a. Certifier Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated. parties basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certile 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar 31. Dete filed (Month-Date

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

DR. FRED SMITH 5401 WESTERN AVE. N.W. WASHINGTON, D.C.

Wester Keelut

to the

U.S.A.

Black, White, etc.

N/A

JACKSON

Physician /Medical **Examiner**

3. Time of Deeth 1997 0444a

9. Birthplace (State or Foreign

10d. tnside City Limits

1 Yes 2 No

Funeral

Director

with the Maryland show Director 28a-f 9 Funeral

by

Completed

Be

Examiner

Physician/Medical

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Certification:

Medicai

27. Menner of Death

1 Netural

2 Accident

3 ☐ Sulcide

4 Homicide

(Check only

the Medical Examiner must be notified at 238 Herra: ŏ "natural"

death filed within 72 hours after i Hygiena. treumatic event, .. Pagas 1 and 2 should be fill thant of Haalth and Mental H tant: If item 27 is marked out Department of Haalth as Important: If item 27 is any injury or other treuonce.

21215-0020

Maryland

Baltimore,

Physician /Medicai Examiner

The law requires that the death certificate be executed buriai-tran and Box 68760. physician use as the the attending p P.O. signed by Division of Vital Records. director, paga 2 should bean Aftar this certificata has Attending Physician: To the Hospital o within 24 hours af To the Funeral DI

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth Month 27, STANLEY WADDY April JR. 4a. Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 1 X M 2 ☐ F 18 Yrs. 579-98-4967 Jan. 27, 1979 CHEVERLY, MD Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location PRINCE GEORGES CHAPEL OAKS 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 1412 EARLY OAKS LANE 20743 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yas, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. 1 Nevar Married 2 Married 1 ☐ Yas 2X No Specify: Specify: BLACK 3 Widowed 4 Divorced Yaar or Datas: 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th UNEMPLOYED 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) STANLEY WADDY, SR. WENDA ANNE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 19e. Informant's Neme/Relationship (Type, Print) WENDA WADDY - MOTHER 1412 EARLY OAKS LANE, CHAPEL OAKS, MD 20b. Pieca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 5-20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removel from Stete 3-1997 WASHINGTON, D.C. 4 ☐ Donetion 5 ☐ Other (Specify) GLENWOOD CEMETERY 21. Signeture of the nerel Service License

TAYLOR'S FUNERAL HOME de 1722 NORTH CAPITOL ST.,

NW WASH. 23e. Pert1. Enter the disease, or complications that causad the deeth. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one coulse on each line. Approximeta Intervel Between Onsat and Deeth

Immediate Cause (Finel disaase or condition resulting in death)

Chest Injuries Due to (or es, consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events rasulting in deeth) Last

Due to (or es e consequenca of):

Due to (or es a consequença of)

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert ii.

23b. Did tobacco use contribute to the causa of death? 1 ☐ Yas 2 ☐ No 3 Probabty WUnknown

24a. Wes en eutopsy

24b. Were autopsy findings eveilable prior to

1 Nes 2 No

completion of causa of daeth?

28. Piace of Deeth (Check only one)

18 Yes 2 No

25. Wes casa raferred to medical exeminer? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No

5 Pending investigation

6 Could not be

28e. Dete of tnjury (Month, Day Year)

4-27-97

28b. Time of Injury 3:51 AM 28c. Injury at Work? 2 No 1 Yes

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred motor vehicle accordant

28f. Location (Street and Number or Rural Route Number, City or Town, State) Add Son & Sherift Rd

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) street 29e. Certifier

Sout Pleasant nd 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the ceuse(s) end menner stated.

29b. Signeture and titia of cartifier

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) April 27, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

hute MD 111 Penn Street, Baltimore, Maryland 21201

State Registra

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State of Maryland / Department of Health and Mental Hygiene

4918 Certificate of Death

Physician	
/Medical	

Examiner	

Funeral Director

Manyland must be notified at death with the items 2 6 "natural"

21215-0020

Baltimore, Maryland

the Medical Examiner filed within 72 hours after I Hygiene. traumetic event. . Pages 1 end 2 should be fill tment of Health and Mental H lant: If Item 27 Is marked oth permit. Pages 1 end 2 Department of Health as Important: if Item 27 Is any injury or other trau

Completed

Be

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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Tol

Certification:

Medicai

The law requires that the death certificate be executed bunel-transit and attending physician the USB 85 signed by or Attending Physician: this funeral After death. within 24 hours efter deatl To the Funeral Director: completely filled in by the In by Hospital

Division of Vital Records, P.O. Box 68760.

1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Watts udo April 18:55 20 4a. Facility Neme (If not Institution, give street end number 4b. City, Town, or Location of Deeth 4c. County of Deeth Taryland Medical System

Taryland Medical System

Taryland Medical System

Tunder 1 Year University of Bathmore If Under 24 Hrs. Hours Min. 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days 226-48-1202 June 2,1939 Virginia Usual Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Washington, D.C. 1 X Yas 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2517 Mozart Pl., N.W. Funeral 20009 U.S.A. 11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: by 1 Yes 2 No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 10 Residence Manager Private Industry 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Henry Watts Elmira Brown 19a. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Katherine Watts/Wife 8225 Tomlinson Ct., Severn, Md., 21144 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 4/26/97 Harmony Memorial Park Landover, Md. 22. Name end Address of Facility
Frazier's Funeral Home, Inc. 21. Signature of Funerel Service Licenses 389 Rhode Island Av., N.W., Washington, D.C. 20001 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. Approximete Intervel Between Onset and Deeth Group A Streptococcal Toxic Shock Byndrome Necrotizing -Immediate Cause (Final disease or condition resulting in deeth) Fascitis Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of):

27. Menner of Death

2 Accident

3 ☐ Suicide

4 \(\text{Homicide} \)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributs to the cause of death? 1 Yes 20 No 24a. Wes en eutopsy performed?

3 Probably 4 Unknown

of Colon Cancer 45+654 25. Was cese referred to medical examiner?

112 Yes 2 No

5 Pending Investigation

Kenal

ulcer

1 Yes 2 N No 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 Yes 2 No

26. Piece of Deeth (Check only one) Hospital: 1 Nnpatient 2 ER/Outpetient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28d. Describe how injury occurred

28e. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

6 ☐ Could not be Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner es steted.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the ceuse(s) end menner stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the ceuse(s) end menner stated. 29a, Certifier (Check only one) 29b. Signature and the of certifier 29c. License number

29d. Dete signed (Month, Day, Year)

cause of deeth (Item 23e) (Type, Print) Shock Shock Tauma

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32. Registrer's Signeture

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Data of Daath **Physician** Month ORRAINE /Medical County of Death 4e. Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death **Examiner** thern ARUM It Undar 1 Year 5. Social Security Number If Undar 24 Hrs. 9. Birthplace (State of Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 2⊠ F 578-30-2700 Yrs. Director Oct. 9, 1919 Washington, D.C. Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Examiner must be notified at Director 1 Yes 2 □ No District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? filed within 72 hours efter death with 4335 Dubois Place, S. E. 20019 United States Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Black, White, etc. Was Decedant of Hispenic Origin? (Specify Yes or No-it Yes, specify Cuban, Maxican, Puerto Rican, etc.) Yes 2 No f Yes, Give Year or Dates: 1 ☐ Navar Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify Specify **Black** 3K Widowad 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Private Housewife 9 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 end 2 should be f nent of Health and Mental Emma Jones Raymond Wilkinson 19a. Intormant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a If item 27 is or other tra 11729 Crestwood Avenue, Brandywine, Maryland 20613 Shirley Wood - Friend 20a. Method of Disposition 20b. Piaca of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Othar (Specify) Fort Lincoln Cemetery 4/29/97 Brentwood, MD 22. Name and Address of Facility
STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C. 20019 23. Part 1. Entar the disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or raspiretory arrest, shock, or heart teliure. List only one ceuse on each lina. Approximate Interval Batween Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in deeth) Cerebral weeks Examiner Physician/Medical Examiner Carcinoma The law requires that the death certificate be executed use es the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, ettending physician for use es the buna Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia. Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? has certificate 1 Yes 2X No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was case refarred to medical 26. Piaca of Death (Check only one) ٩ 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funerai Certification: 27. Manner of Death 28b. Time ot 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 28c. Injury at Work? After 5 Pending Investigation 1 Naturei ours efter death. Neral Director: A rfilled in by the fi 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 D Homicide 6 To the Hospital of within 24 hours of To the Funeral Di completely filled in Medical Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of cartitier 29c. Licansa number 29d. Data signed (Month, Day, Year) Goll D0050653. 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) SURANA 7501. Surrates Road-Clinton -31. Date tiled (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4920 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** 10:41 erov April 22 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Death Wempli trederic alver 02 If Under Year rince t 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Days Hours Yrs. 579 12 5495 Director 78 4, 1918 Virginia Nov. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County ahow 10d. Inside City Limits r than "natural", or items 23s or 28s-f ahor the Medical Examiner must be notified at Funeral Director ★NYes 2 No Maryland Prince George's Glenn Dale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11336 Old Prospect Hill Road 20769 death United States 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after ☐ Yes 2 ☑ No f Yes, Give 0 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: by 3 Widowed 4 □ Divorced Year or Detes White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Builder Pages 1 and 2 should be filed viment of Health and Mental Hygie tantil frem 27 is merked other to lury or other traumatic event, to Construction 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles E. Wood 2 Susie Gay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zlp Code) 11336 Old Prospect Hill Road Glenn Dale Md. 20769 Bradley Wood Son 20a. Method of Disposition
1 □ Burlal 2 □ Cremetion 3 □ Removel from State 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery April 25, 1997 Brentwood Md. e of Funeral Service Lices 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. mis 16000 Annapolis Rd. Bowie Maryland 20715 Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Im ate Cause (Final diseese or condition resulting in death) Examiner to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initioted events resulting in death) Last bunial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buna Physician/Medical the Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the ate has been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown Records, P Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Menner of Deet Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28h. Time of 28d. Describe how injury occurred After 5 Pending Investigation death. 2 Accident 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: A the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and menner stated. Medicai 29a. Certifier tely (Check only one) 29b. Signeture and title of certific 29c. License number 29d. Dete signed (Month, Day, Year)

ause of deeth (Item 23e) (Type, Print)

37. Registrar's Signeture

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State Registrar 30. Name and eddress of person who comp

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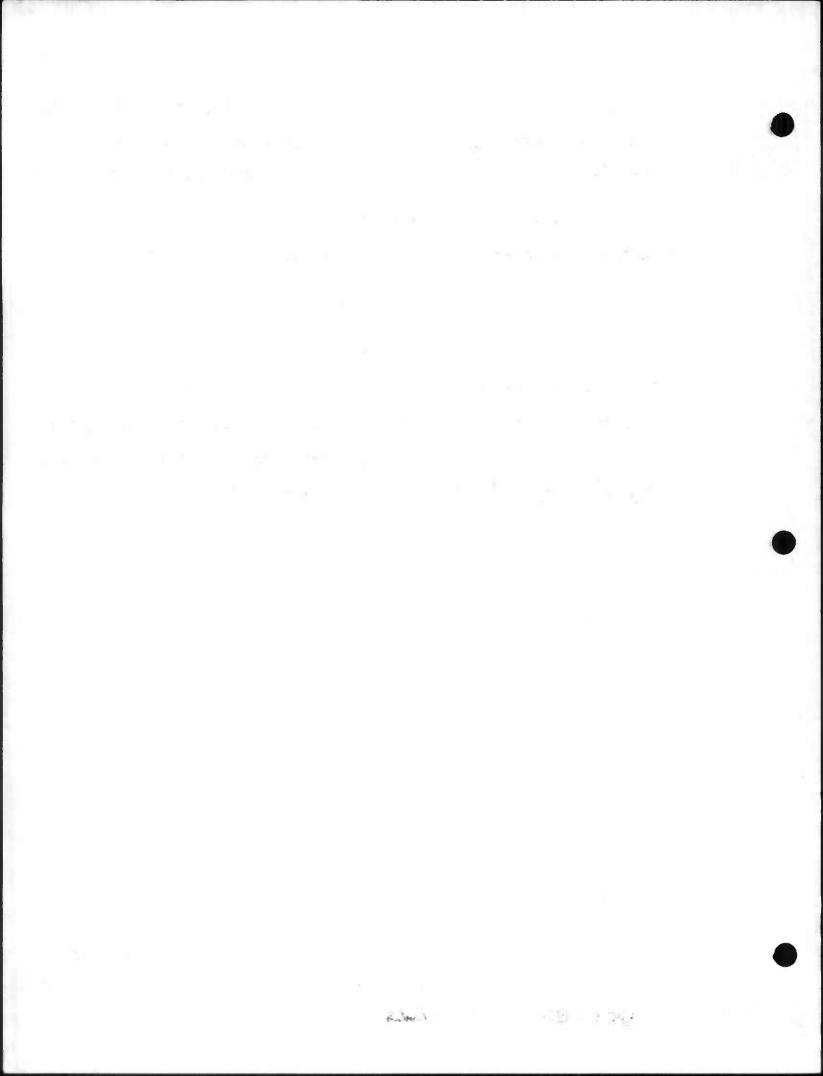
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day **Physician** 4:10AM APRIL 26 1997 Kobert Washington /Medical 4a. Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY Months Deys Hours Min. JULY 2, 1950 WASH. 5. Social Security Number Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Months 66 5521 10XM 2□ F 579 46 Yrs. Director Usuei Rasidanca ot Dacedant with the Meryland 10a. Stata 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Manylan Department of Heelth and Mentel Hygiene.
Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumstic avent, the Medical Example mast be notified at once. 10d. Inside City Limits MD. P.G. 1 XYas 2 No GREENBELT Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 9284 EDMONSTON ROAD 20770 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, Whita, etc. 1 ☐ Yas 2X No If Yas, Giva Yeer or Detas: 1 Navar Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes ② ☐ No Specify: þ Specify: BLACK 3 Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Dacedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Etementary/Secondery (0-12) Cottege (1-4or 5+) COMPUTER OPERATOR PVT. 12 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) ROBERT J. WASHINGTON DORIS FLETCHER 2 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) GWENDA GREEN/FRIEND 9284 EDMONSTON RD. GREENBELT, MD. 20770 20b. Pleca of Disposition (Nama of cematary, cremetory or other plece) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stete 1 XBurlal 2 Cremetion 3 Ramovat from Stata MAY 1 1997 LANDOVER, MD. 4 □ Donation 5 □ Othar (Specify) HARMONY MEM. CEM. 22. Neme end Address of Fecility WATSON F. H. INC. 3435 14th ST., N.W. 20010 23a. Pert1. Entar tha disaase, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, of heart failure. List only one cause on each line. Approximata Intarvet Between Onsat and Death Physiclan Immadiata Causa (Finat disease or condition rasulting in deeth) /Medical one day sthma Examiner Dua to (or es a consequence of): Examiner physician and the buriel-transit Sequentially list conditions, if eny, leading to immediata cause. Enter Underlying Cause (Disaasa or injury that initiated evants resulting in daath) Lest Due to (or as a consequence of): Box 68760 requires that the death certificate be Physician/Medical Dua to (or as a consequence of): 88 980 jo Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 0 23b. Did tobacco use contribute to the cause of death? the signed by 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 X Unknown Obstructive pulmonary disease Division of Vital Records, by 2 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Wes an eutopsy performed? Completed Deed page 2 hes 1 Yas 2 No 1 □ Yas 2 No certificate 25. Was casa ratarred to medical axaminar?
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the Funeral Direction of the filled in by the 6 Could not ba 3 Suicide 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of tnjury - At homa, tarm, streat, tactory, office building, atc. (Specify) 4 Homicide Hospital 29a. Cartifiar Medical 🔁 Certifying Phyelcian: To tha bast ot my knowledga, daeth occurred et tha tima, data and place, and dua to tha causa(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, deta end place, and due to the causa(s) end mennar steted. To the Vithin 2 29b. Signatura and title of certifiar 29c. License number 29d. Data signed (Month, Dey, Year) Steven Osborne MO D 30898 04/26/97 30. Name end eddrass of parson who complated cause of death (Item 23e) (Type, Print) Plum Orchard Road Silver Spring, MO Steven Osborne MO Kaiser Permanente

State Registrar 31. Data tiled (Month, Day, Year)

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2. Dete of Deeth Month

Day 0.20 AM

3. Time of Deeth

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medicai **Examiner** To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after deeth.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-trensit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Month Day **Physician** James Milton Wenk 7:20 am April 26, 1997 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham 8. Date of Birth (Month, Day, Ye Tune 20, If Under 1 Year If Under 24 Hrs. 9. Birthplaca (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 1⊠ M 2□ F 217-82-4956 30 Yrs **Director** Usual Residence of Decedent the Maryland 10a. State r 28a-f show 10b. County 10c. City, Town or Location 10d, Inside City Limits 1⊠ Yes 2□No Maryland | Prince George's Hyattsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? tem 27 is marked other than "naturel", or items 23s or other traumetic event, the Woulds! Examiner must be a 5303 Chesapeake Road 20781 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. illed within 72 hours after 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 2 No Specify: by Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. merked other than Elementary/Secondary (0-12) 8 th College (1-4or 5+) Private Industry Handyman permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is merked other any injury or other traumetic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Joseph Edward Wenk Rose Mae St. Clair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Rose M. Wenk - Mother 5303 Chesapeake Road, Hyattsville, Maryland 20781 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/97 Suitland, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2⊠ No 3 Probably 4 Unknown s been signed to should be dete Records, by 24b. Were autopsy findings available prior to 24e. Was an autopsy Completed completion of causa of death? page 2 1 Yes 2 No 1 Yes 2⊠ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 ☐ Yes 2 ☒ No 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide 29a. Certifier 1 Certifying Phyalcfan: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certific 29c. license number 29d. Date signed (*Month*, *Dey*, *Yeer*)
4/28/97. SARVIS. Riverdale ut 20737. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STILL CONTROL OF CON 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 16 Ray 6/95

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4925 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death 3. Time of Death **Physician** 0845 h MS / No Abra /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Helel If Under 24 Hrs 4709 Churc 620 10 Legryes If Under 1 Yea Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 579-12-7033 10 M 20 F Yrs Director 84 March 13, 1913Petersburg, VA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 No Prince Georges Director Mitchellville 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with permit. Peges 1 and 2 should be filed within 72 hours after death v
Department of Health and Mentel Hygiene.
Important: If Item 27 is marked other than "natural", or items 23s, any injury or other traumatic event, the Medical Experience 23s, and injury or other traumatic event, the Medical Experience 23s, and injury or other traumatic event, the Medical Experience 23s, and injury or other traumatic event, the Medical Experience 23s, and injury or other traumatic event, the Medical Experience 23s, and injury or other traumatic event, the Medical Experience 23s, and injury or other traumatic event, the Medical Experience 23s, and injury or other traumatic event, the Medical Experience 23s, and injury or other traumatic event, the Medical Experience 23s, and injury or other traumatic events. U.S.A.
14. Raca - American Indian,
White, etc. Funeral 4709 Church Road 20720 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify by Specify Black 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Supv. Binding Dept. of Navy 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James E. Byrnes Carrie J. Harris 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Doris Williams 4709 Church Rd. Mitchellville, MD. 20720 Daughter 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park 5-2-97 Landover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses Marshall de s funeral Home, Inc. 4217 9th Street N.W. Washington DC 20011 Ilans 23a. Part Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart feilure. List only one ceuse on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Fine disease or condition resulting in death) ovelidasca la terio coleratio Examiner Due to (or as a consequence of): Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and bunal-tran Due to (or as a consequence of): Box 68760. physician Physician/Medicai the Due to (or es e consequence of): Se esn signed by the atte Part II. Other/significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown pertension þ 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes en autopsy performed? peen hes this certificate 1 Tes 2 1 No 1 ☐ Yes 2 ☐ No Division of Vital is or Attending Physician: The safer death.

It Director: After this certificate of in by the funeral director, pa 25. Wes case referred to medical exempler?
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier Action Mill. L Ru 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) end address of person who completed cause of deeth (Item 23e) (Type, Print)

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DHMH 16 Rsv 6/95

State

Registrar

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31. Date filed (Month, Day, Year)

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32. Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

14926

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permit. Pages 1 and Department of Health Important: If item 27 any injury or other to ansists.		20e. Method of Disposition		20b. Plece		sition (Neme of natory or other pla		Dete	20c. Location -		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Box 68760. Division of Vital Records, P.O.

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2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner stated. 29b. Signeture and title of captiffs of person who completed ceuse of deeth (Item 23e) (Type, F "SLATURY PD SAMTANI 31. Dete filed (Month, Dey, Year)

State APR 29 Registrar

Registrer's Signeture

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Physician /Medical Examiner

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Examiner

10a. State

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permit. Pages 1 and 2 should be filed within 72 hours after c Department of Haalth and Mental Hygiene. Important: if item 27 Ia marked other than "natural", or item any injury or other traumatic event, the Medical Examines once.

Baltimore, Maryland 21215-0020

the Maryland

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the tuneral director, page 2 should be deteched for use as the buriel-transit Physician/Medical þ Be Completed Certification: To Medical

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions Angina	contributing to death but not re			23b. Did tobacco use co	ontribute to the cause of death? 3 ☐ Probably 4 ☑ Vinknow
				24e. Wes en eutopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of deeth? 1 Yes 2 No
25. Wes case referred to medical exeminer? 1 Yes 2 No	Hospitel: 1 npatient 2	☐ ER/Outpatient 3☐	Other	eeth (Check only one) Home 5 ☐ Residence 6 ☐Ott	her (Specify)
27. Menger of Death 1 Neturel 5 Pending 2 Accident Investiget	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work? 1 Yes 2 No	28d. Describe how injury occur	
3 Suicide 6 Could not determine		nome, ferm, street, fec	tory, office	28f. Location (Street end Num. City or Town, Stete)	ber or Rural Route Number,
29e. Certifier (Check only one)	Physician: To the best of my known in the basis of exeminating end manner steted.	owledge, deeth occurr ation end/or investiget	ed et the time, dete end plecion, in my opinion, deeth occ	ce, end due to the cause(s) and mourred et the time, date end pleca,	anner as steted. end due to the cause(s)
29b. Signeture end title of certifier	7 440		29c. License number	1	ed (Month, Dey, Year)

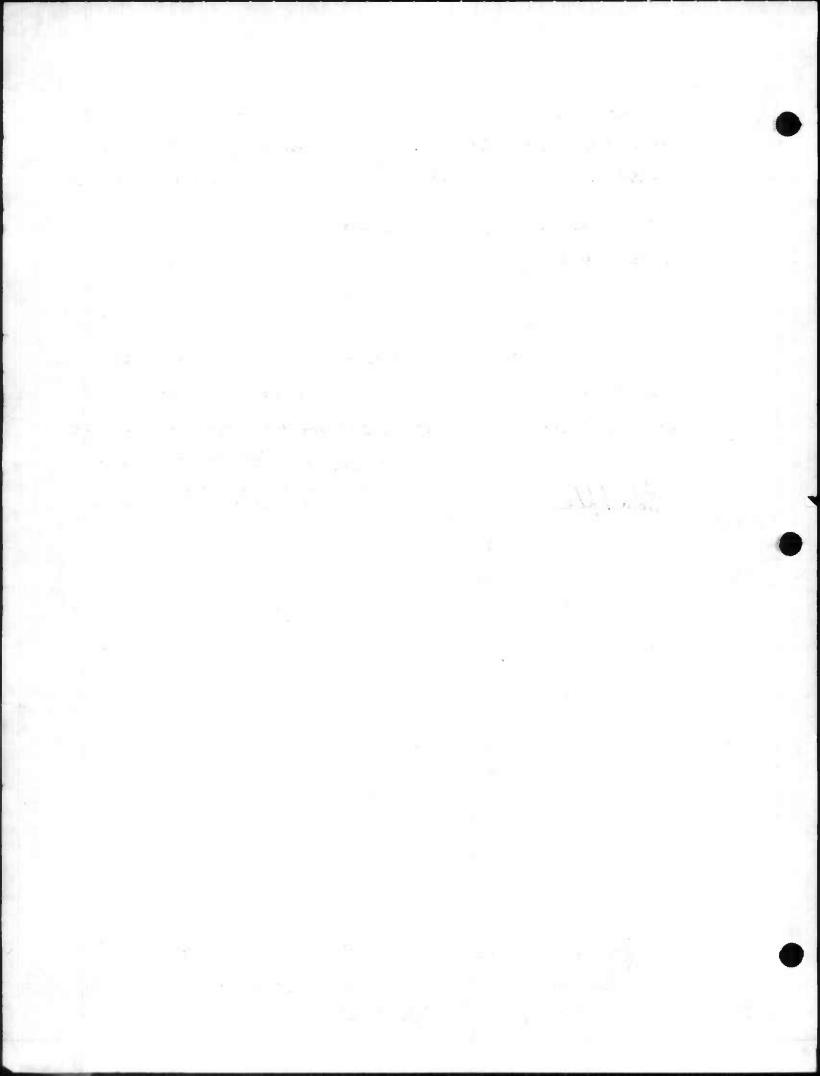
7610 Carroll Ave, Takoma Park, MD

State Registrar Bobby

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

MD

David



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month **Physician** 1997 ELIZABETH VERNA ADOLPH MAY 10, 10:16 P.M. /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FALLSTON GENERAL HOSPITAL FALLSTON HARFORD 8. Date of Birth (Month, Day, Y AUGUST 13, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplace (Steta or Foreign Country) **Funeral** Months Days Hours 1□M 2□F Yrs Director 218-09-7838 BALTIMORE, MARYLAND 1919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo MARYLAND BALTIMORE KINGSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 VISTA VIEW COURT 21087 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes > (X No þ lf Yes, Give Yeer or Dates: Specify: 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedent's Education (Spacify only highest grada complated) 16b. Kind of Business/Industry pemit. Pages 1 and 2 should be filed within Department of Haalth and Mantal Hygura-Important: If item 27 is marked other than any injury or other traumatic event, the Max Elementery/Secondery (0-12) College (1-4or 5+) 12 CAFETERIA WORKER OCOEE CO. SCHOOL SYSTEM 17. Father's Neme (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Sumama) Be DAVID EDWARD LEASE ANNIE RIEMENSNYDER 10 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) ANN C. HOFFA (DAUGHTER) 2 VISTA VIEW COURT KINGSVILLE, MARYLAND 21087 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH CBM. MAY 14, 1997 BALTIMORE, MARYLAND 21. Signature of Funeral Servica Licanses 22. Name and Address of Fecility E.F. LASSAHN FUNERAL HOME, P.A. 11750 BELAIR ROAD KINGSVILLE, MARYLAND 21087-1351 23a. Part 1. Enter the disease, or complications that caused in shock, or heart feilure. List only one cause on each line Approximete Interval Between Onset and Death the death. Do not enter the mode of dying, such es cardiac or respiratory **Physician** /Medical Immediate Cause (Final disease or condition resulting In deeth) Examiner Bacteri bunial-transi Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and physician s the burial Physician/Medical Due to (or as a consequenca of) ed by the al Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24e. Wes an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? Completed 1 🗆 Yes 20 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2⊠No this funaral 28a. Dete of Injury (Month, Dey Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Menner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how Injury occurred 5 Pending investigation Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a, Certifler Medical 29b. Signature and title of certify 29c. License number MD -8-0 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Belair Road, Fallston

2112

32. Registrar's Siena

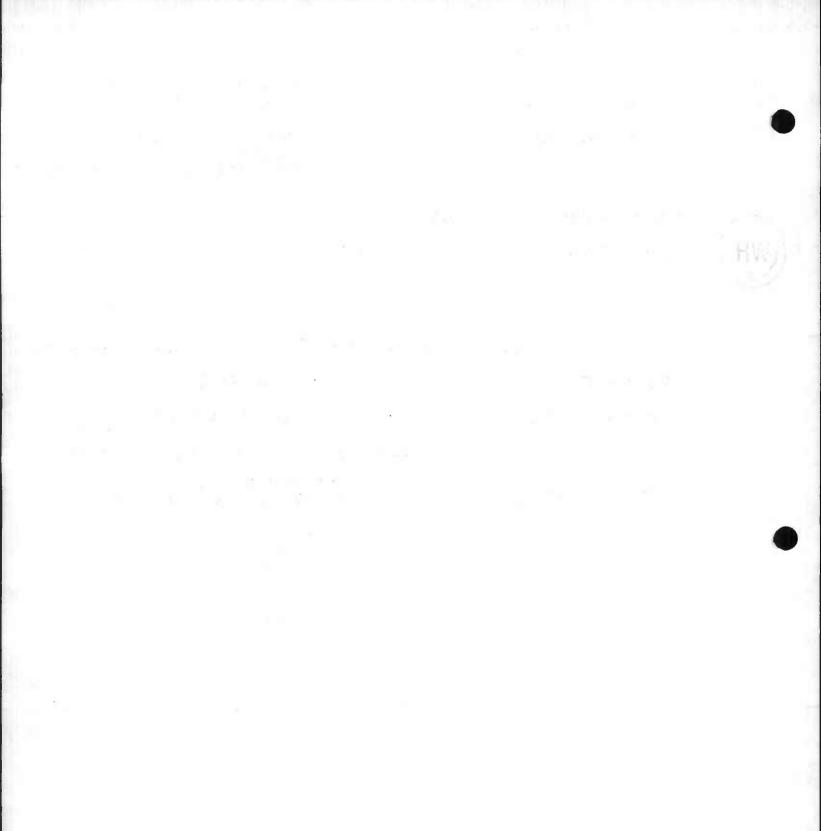
State Registrar

Baltimore, Maryland 21215-0020

Box 68760

Records, P.O.

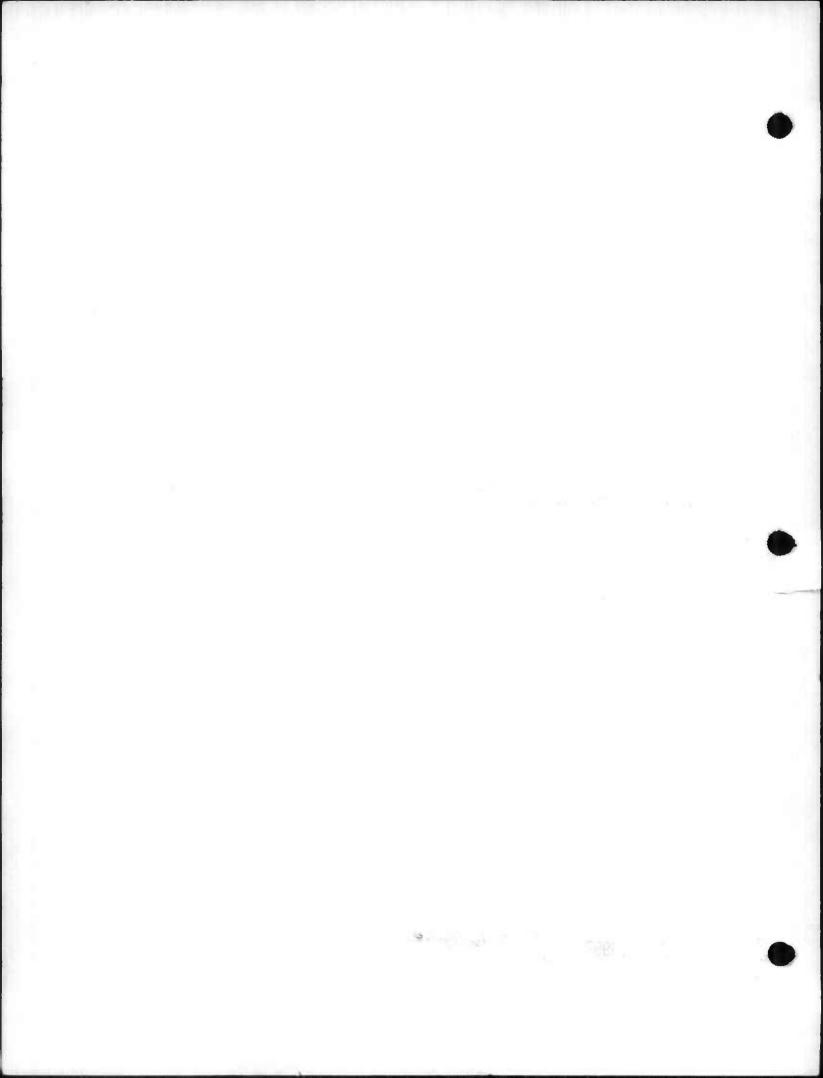
Division of Vital



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E E	10a. STATE	10b. COUNT	Υ		10c. CITY	, TOWN C	OR LOCAT	ION				-	1	10d. INSIDE CITY
#	Maryland				Bal	ltim	ore							LIMITS?
A I	10s. STREET AND NUMBER						101	. ZIP COD	E			10g. CITIZ	ZEN OF WH	IAT COUNTRY?
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BE CO	unknown								nkno		Middle, Maiden	Sumame)		
2	19a. INFORMANT'S NAME (1 UNKNOWN	Type/Print)			196. MAILING UNKI	ADDRESS NOWN	S (Street a	ind Numbe	r or Rurel I	Route Num	ber, City or Tox	vn, State, Zip	Code)	
	20a. METHOD OF DISPOSIT	on 3 🗆 Rem		20b. PL	ACE OF OISPOS er place)	BITION (Na	ame of cer	metery, cre	natory or		20c. LC	DCATION (City or Tow	m, State
	4 ☐ Donation 6 ☒ Other 21. SIGNATURE OF FUNERA	L SERVICE LI	CENSEE	_		22.	NAME A	ND AODRE	SS OF FA	CILITY			-	
	Joseph	B. ya	n-Sant_	1									. Bal	timore S
	boom 13	3./0	- Henry				n - 1 -	2	- 3.6	-	1 01	1201		
	23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fi disease or condition resulting in death)	eart fallure.		use on each	death. Do n	not enter	the mo	de of dy	ing, suc	h aa can		piratory arm	est,	Interval Bety
TIFICATION	shock, or h IMMEDIATE CAUSE (Fildisesse or condition	tions, diete ling	a. DUE TO	O (OR AS A CO)	M 5 0 (5	F):	the mo	de of dy	ing, suc	h aa can	diac or reap	Diratory arr	est,	Interval Betv
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1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth BERKOW **Physician** ROSE ^D1^y997 MAY 12, 11:40pm /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner BALTIMORE SINAI HOSPITAL If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth
(Month Dey Year)
MAY 28,1910
MARYLAND 9. Birthplece (Stete or Foreign **Funeral** 1□M 2₩5 219-10-4045 86 Yrs Director Usual Residence of Decedent the Marylend 10e Stete 10b. County 10c. City, Town or Location 28a-1 show 10d. Inside City Limits traumetic event, the Madical Examinar name be notified at BALTIMORE MARYLAND N/A Director 1 □XTes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 21215 USA 2500 W. BELVEDERE AVE., APT. 202 permit. Pages 1 end 2 should be flied within 72 hours after death v Depertment of Health end Mentel Hygiane. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Franchiscopies. Funeral 12. Wes Decedent Ever In U.S. Armed Forces?, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Reca - American Indien. Bleck, White, etc. 1 Yes 2 40 tt Yes, Give Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: WHITE à 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) SECRETARY CITY OF BALTIMORE 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middla, Maiden Surname) Be BERENSON **ANNA** ROYPEN IKE 19a. Intormant's Neme/Ralationship (Type, Print)
MRS. MYRA MILLISON (NIECE) 19b. Mailing Addrass (Street and Number or Rurel Routa Number, City or Town, State, Zip Coda)
2833 BANEBERRY CT. BALTIMORE, MD 21209 20e. Mathod of Disposition 20b. Pleca of Disposition (Name of 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State MOSES MONTEFIORE -5-15-1997 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Neme end Address of Fecility SOL LEVINSON & BROS., INC. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, pr heart teilure. List only one cause on each lina. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Approximete tntervel Between Onset and Death **Physician** /Medical Immediata Cause (Finel disease or condition resulting in daeth) 14m0715 Examiner Due to (or as a consequence ot) Physician/Medical Examiner PIGTION physician end the burial-transit The law requires that the deeth certificete be executed Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of). Box 68760. Due to (or es e consequenca ot): 89 for use es P.O. ed by the e Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed by should b 24b. Wera eutopsy findings 24e. Wes en eutopsy avelleble prior to complation of cause of death? performed' pege 2 s certificata hes 2 1 No 1 Tas 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Wes case raferred to medical examiner? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funerel 27. Manner of Deeth 28e. Data of Injury (Month, Dey Year) 28b. Tima of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Natural 5 Pending Investigation deeth. 1 Yes 2 No 2 Accident ofter deeth Director: 6 Could not be determined 3 ☐ Sulcide 281. Location (Street end Number or Rural Route Number, City or Town, State) Plece of Injury - At home, term, street, tectory, office building, etc. (Specify) 124 hours effer the Funeral Direct pletaly filled in b 4 Homicide Hospital 1 Certifying Physicism. To the best of my knowledge, deeth occurred et tha tima, data end placa, and dua to tha ceuse(s) and menner es stated.
2 Madical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical (Check only 29b. Signeture end title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name end addrass of person who sompleted cause of daeth (Item 23a) (Type, Print) Sinai Hosp of Baltimore, MD 21 Registrar's Signature State Registrar

DHMH 16 Rev 6/95

34.4.3. A. 2.2.3. 1961 A. 1975

State of Maryland / Department of Health and Mental Hygiene

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						(Cer	tificate of	f Death	7		Reg. No.		' '	14700
П	Dhunin	lon	1. Decedent's Name (First, Mic	ldle, Last)							2. Dete of D Month	eath		Vans	3. Time of Death
J	Physic /Medi		JOSEPH		W.			BERNS	STEIN		MAY	13, Day	997	Year	9:35pm
	Exami		4a. Fecility Name (If not Institut	ion, give street end	number)			= -	4b. City, To	own, or L	ocation of Dea	th 4c. C	ounty o	of Death	
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	Registr		MAY 1 5 199	7 gul	David	son-Randa	AL.								

FLM#G747 J.A. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM#20PER F.H. 5/21/97 State of Ma Items8,20b,20c 5-15-97 FilmG747 W.H.Per F/H Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Tima of Death Month **Physician** Day Year 1997 8:25 HANNAH RHEA BARNES MAY 14, /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN
if Under 24 Hrs. 8. Data of NORTHWEST HOSPITAL CENTER BALTIMORE 5. Social Security Number if Under 1 Year Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. lest birthday) 8. Data of Birth 1926 (Month, Day, Year) **Funeral** Days 1 □ M 2 □ F Min Yrs. Director 216-20-2292 71 MAR. 5, 19126 MARYLAND Usual Rasidence of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at MD BALTIMORE BALTIMORE Director 1 Yes 2 No 10e. Street and Number 722 GREENWOOD ROAD 10f. Zip Code 10g. Citizen of Whet Country? daath with 21208 USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 22 No If Yas, Giva Yaar or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - American Indien, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after comportant: If the 27 is marked other than "natural", or han any injury or other traument. 1 □ Navar Merried 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: þ Specify. 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grada completed) Elamentary/Secondary (0-12) Collega (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middia, Maidan Sumama) ABRAHAM THIMAN LILLIAN MERMELSTEIN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 722 GREENWOOD ROAD BALTIMORE, MD 21208 MR. WILLIAM F. BARNES (HUSBAND) 20b. Piaca of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete Data 2 Cramation 3 □ Ramoval from State 4 □ Donation 5 □ Othar (Specify) Hilltop Service Corp Towson 5-15-97 DRUID RIDGE BALTIMORE, MD 21. Signature of Funaral Service Licansaa 22. Name end Addrass of Facility SOL LEVINSON & BROS., INC. Jumos 8900 Reisterstown Road Pikesville, MD 21208 23a. Part1. Entar tha disaasa, or complications that caused the daath. Do not antar the moda of dying, such as cardiac or respiretory arrest, shock, or haart failure. List only ona cause on each line. Approximata Intervel Batwaan Onsat and Death **Physician** /Medical Immediate Causa (Final diseasa or condition rasulting in daath) Examiner Examiner buriel-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Diseasa or injury that initiated evants rasulting in daath) Lest and physician a Physician/Medical usa Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa givan in Part I. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evelleble prior to completion of cause of death? 24a. Was an autopsy performad? Completed peen has page 2 2 No cartificate 1 □ Yas 2 □ No Hospital or Attending Physician: 25. Was case rafarred to madical Be 26. Placa of Daath (Check only ona) Hospital: 1 Yas 2 No Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 ☑Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Certification: To this funaral 28a. Date of Injury (Month, Day Year) 27. Manner of Daath 28b. Tima of 28d. Dascribe how injury occurred 28c. Injury at Work? Aftar 5 Panding invastigation 1 Natural daeth. 1 □ Yas 2 □ No 2 Accident 24 hours efter daet 6 Could not be datarmined 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28e. Piaca of Injury - At homa, ferm, straat, factory, office building, etc. (Specify) 4 | Homicida Confifying Physician: To the bast of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and mannar as stated.

23 May cal Examiner: On the basis of axamination and/or investigation in my calculated and place. Medical 29a. Cartifian plately cal Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, data and placa, and due to tha causa(s) end mannar statad. (Check only one) within 2 29b. Signature and title 29d. Date signed (Month, Dey, Year)

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State Registrar

Box 68760.

P.O.

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Mary John M.

			State	or Marylar		artment of rtificate of	Health and Death		giene Reg. No.	97	14936
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/Med	icai	Olav (Olaf)						May	12 19	997	5:45 M
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2 *		Usual Residence of Decedent 10e. Stete 10b. County		100 0	ity, Town or Lo	antina					
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\n		30. Name end eddress of person	who completed caus	se of deeth (Item	n 23e) (Type, I	Print)		•			/
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DHMH 16 Rev 6/95



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LIE MARIE BULKLEY

State of Maryland / Department of Health and Mental Hygiene

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Baltimore, Maryland	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylan Depertment of Health end Mentel Hygiene. Infortant: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examinar must be not red at once.		21. Signeture of Funeral Service	Licensee	1		2. Name end Addr							
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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 97 14939

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	Physic /Medi			THEL	MA	В.			19	COH	EN			Y 14	Day 1997	Year 7	3:	55AM
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т	Funeral	г	5. Social Security	Number	6. Sex	7. Age (In	yrs. last birth	day)	If Under 1		If Under 2	4 Hrs.	8. Date (Moni	of Birth		9. Births	place (S	State or Foreign
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Division	がまるこ	Certification:	4 🗆 Homicide	dotorr	build	ling, etc. (Sp	ecify)		,				City	or Town,	Stete)			
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	Hos 24 h Fun etely	edical	(Check only one)	2 Madical	Examiner: On the b	pasis of exen	nination and/o	or inve	stigation, l	n my o	plnion, death	occurr	ed at the	time, dat	e and place	, and due to	o the ca	iuse(s)
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	. 9		30. Name and add	tress of person	who completed cau	se of death ((Item 23a) (Ty	pe P	(Int)	01	01/11-	1 1	1 0	1	1.	100	1.	1/2/
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Section 1, 1965

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedeni's Name (First, Middle, Last) 2 Data of Death 3. Time of Death Month Physician (Vicillia 7:10 PM Mas /Medical 4a. Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LIBERTY MED. CENTER BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 12 22 1912 9. Birthplace (State or Foreign Country) VIRGINIA 7. Age (In vrs. last birthday) **Funeral** 100 M 2□ F Months Days Hours 217-22-8221 84 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Director MD N/A BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21216 U.S.A. 1720 ASHBURTON ST. Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 M No if Yas, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. In mornint: if item 27 is marked other than "natural, or fee any injury or other traumetic event, the Medical Evantine. 1 ☐ Naver Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: AFR. AMERICAN by 3 Ø Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN DOMESTIC WORKER DOMESTIC (HOME) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN NOBIE SPENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLISSA HOGAN (DAUGHTER) 1720 ASHBURTON ST. BALTO. MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/14/1997 BALTO. MD ZION CEMETERY 21. Signature of Funeral Service Lipensee ESTEP BROTHERS FUNERAL HOME P.A. Part i Enter the disultage for complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock to heart failure. List only one capte in each line. 1300 EUTAW PLACE BALTO. MD 21217 Approximata Interval Between Onsat and Death **Physician** Probable Pulmonary Emboli /Medicai Immediate Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of): ronic Deep Venous Thrombosis Physician/Medical Examiner Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Bradyauch Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contributs to the cause of geeth? 1 Yss 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed' 2 No 2 No 1 ☐ Yes 1 Yes Be 25. Was cese refarred to medical examiner? 26. Placa of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 27. Manger of Death 28c. injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and litle of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) ly MT M.D. 041365 .2

State Registrar

32. Registrar's Signature the Midson

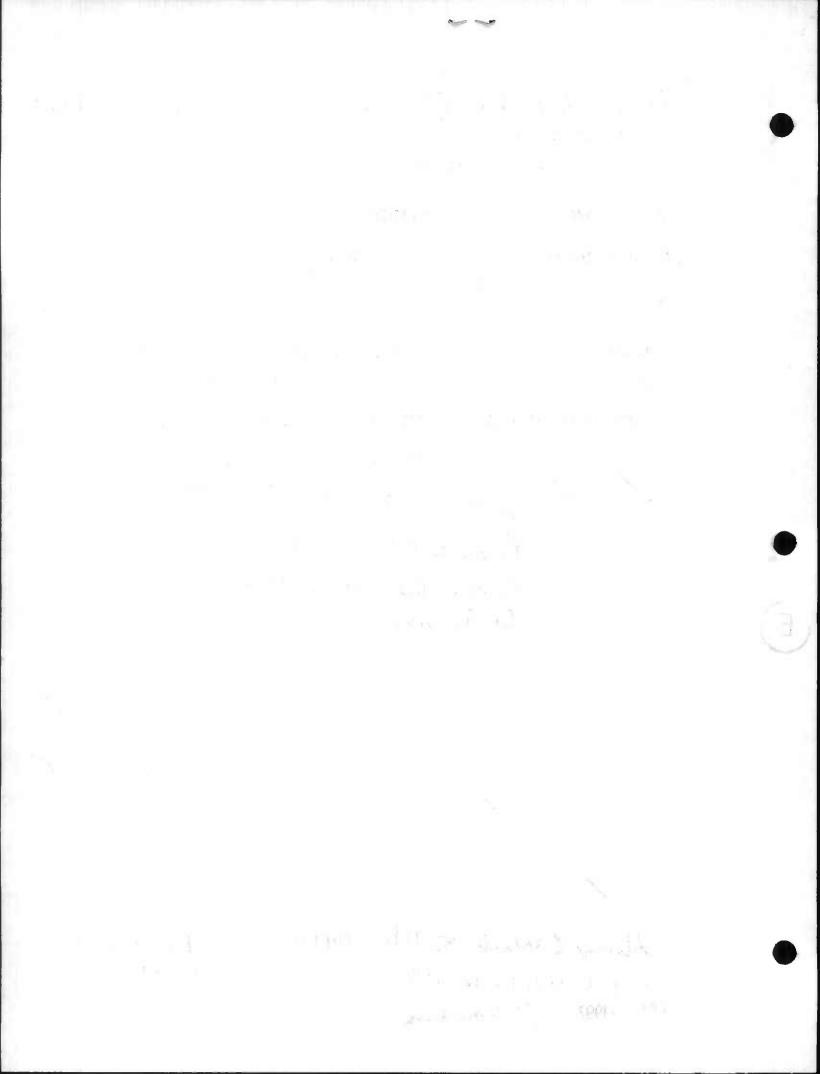
2600 Liberty Keights Ave.

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

led (Month, Day, Year)

1 5 1997

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State of Maryland / Department of Health and Mental Hygiene 14941 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** MAY 11, 1997 MARY M. CRYSTAL 2:30 P. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner RAVENWOOD NURSING CENTER BALTIMORE N2A If Under 24 Hrs. 8. 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) 9. Birthpiace (State or Foreign **Funeral** Deys 1□M 2♥F 228-05-9046 82 Yrs. VIRGINIA Director Usuei Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ¥ Yes 2 □ No Director MARYLAND N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g, Citizen of Whet Country? 6 325 E. 28 STREET. 21218 USA itams 23a death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: Wes Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca · American indien, Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Nem 27 is marked other than "natural", or than any injury or other traumatic event. The page 1000. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No þ 3 Widowed 4 ☐ Divorced Specify: AFRO. AMERICAN Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) UNKNOWN UNKNOWN 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be **POWER** CERRIE POWER **FLECTHER** 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 325 E. 28th STREET, BALTIMORE, MARYLAND 21218 ELIZABETH GRAY 20b. Place of Disposition (Name of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☐ Cremetlon 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) KING MEMORIAL PARK 5/16/97 RANDALLSTOWN, MD. 21. Signeture of Funeral Service Licensin ESTEP BROTHERS FUNERAL HOME, P. A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that a used the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or healt hillure. List only one cause of each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediate Cause (Finei PNEOMONIA diseese or condition resulting in deeth) Examiner Physician/Medical Examiner HEMORRHAGE INTRACRANIAL Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that in rilieted events resulting in deeth) Lest Due to (or es e consequence of): 68 Records, P.O. Box The law requires that the death ate has been signed by the e page 2 should be detached it Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No of Vital or Attending Physician: Certification: To Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpetient 3 DOA this the funeral 27. Menner of Deeth Dete of Injury (Month, Dev Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred After Division Natural 2 Accident 5 Pending investigation s efter death. 1 Yes 2 No 6 Could not be determined 3 Suicide in by t 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 I Homicide the Hospital 24 hours textifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pieca, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the ceuse(s) and menner stated. 29e. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29b. Signeture end title of certified 29d. Date signed (Month, Dey, Yeer) 13th May 1997 asanthal cuma min 142510 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) M VACANTHAKUMAR, 821 N. EUTAWST. SULTE 407, MD 2/201

State Registrar guia Javidon-Mines

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State of Maryland / Department of Health and Mental Hygiene

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	_/Medi		4a. Fecility Nama (If not institution, giva	etreat and number)		CU,		or Location of De	212	1997	9:34 A
	Exami	ner					4b. City, Town,	or Location of De	4c. Coun	ty of Death	
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yla	Went	0	Louis Cohen				Mo1	lie (Unk	(nown)		
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Division	or A Direction	Certification:	4 ☐ Homicida detarminad	28a. Place of Injury - building, etc. (S)		straat, factory, on	ice		own, State)	ber or nura	r noura rumber,
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	,'0		30. Nama and eddress of person who co	mpiated ceusa of death	(Itam 23a) (Tvn	e, Print)				-	
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State Registrar



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			Olate of I	viaiyiai		tificate of	Death	viciliai i iy	Reg. No.	97	14943
Physic	an	Decedent's Name (First, Middle, IO GENEVI IO GENEVI III III III III III III III						2. Date of De Month	Day	Year	3. Time of Death
/Medi		JOSEPH 4a. Facility Name (If not institution,	MABREY		CLARKE	17	4b. City, Town, or I	May ocation of Deat	13	1997 ty of Death	13 PM
Exami	ier	11	ionial	405	nita		12	more		I/A	
Funeral Director				Age (In yrs.	Vast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da		9. Birthplac	ce (State or Foreign
2 .		Usuai Residence of Decedent 10a. State 10b. County		10c Ci	ty. Town or Lo	cation			1, 1210		
Maryti 4 sho	0	Maryland N/	٨		altimo					100	f. Inside City Limits 17☑ Yes 2☐ No
28a notif	Directo	10e. Street and Number	n	D	artillo.	10f. Zip Code			10g. Citizen of	What Country	
A N		5512 Purdue Ave	nue			21	L239		U.S	S. A.	
WH.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorcad	12. Was Decade Armed Force d 1 Yes 2 If Yes, Give Year or Date	s? XNo		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 21 No	dispanic Origin? (Si an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. Ra	ack, White, etc	
21215-0 d within 72 he giene. rr than "natur	Completed	15. Decedent's (Specify only highest Eiementary/Secondary (0-12) 12 years	Education grade completed) College (1-4d	or 5+)	(Give life. L	lent's Usual Occup kind of work done 20 NOT use retired	pation during most of world)	king		Business/Indu	
	Be C	17. Father's Name (First, Middle, L.	est)			Spector	18. Mother's Nam	ne (First, Middle			raractar fir
ylai Nanta Manta arkad artic e	TOE	Joseph	Cla	rke			Edith		Foster		
Maryland 42 should be file th and Mental Hy 7 is marked othe traumatic event		19a. Informant's Name/Relationshi					end Number or Ru	ral Route Numb	er, City or Town	n, State, Zip C	ode)
		Opal Clarke 20a. Method of Disposition	(wife)	20h F		Purdue A		imore,			
nor of the fit is		1 Burial 2 Cremation 3	Removal from Sta	16		sition (Neme of natory or other place			20c. Location		
Baltimore, eemit. Pages 1 ar Separtment of Hea mportant: If Hean 3 iny injury or other MSS.		21. Signature of Funeral Service LI		Gre	een Mou	nt Crema Name and Addre	tory 5	-16-97	Baltır	nore, M	Maryland
m and and		19			Mi	tchell-W	iedefeld	Home			
Physician /Medical		23e. Pert1. Enter the disea e, or c shock, or heart failur List of			h. Do not ente	er the mode of dyln		or respiratory a	rrest,	A Ir	pproximate hterval Between Inset and Deeth
Examiner		disease or condition resulting in death)	aK	12111	or as a conseq	y Fa	llure			0	l wks
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O. Box (a death certifi the attending hed for use a	sicia	Part II. Other significant condition	s contributing to death	but not res	ulting in the un	derivina ceuse aiv	en In Part i.	23b. Did	tobacco use c	ontribute to th	he cause of death?
S, P.O. BOX as that the death cer gned by the attendir be deteched for use	by Physician/M	Carotic Prostate			disec				Yes 2□ No		bly 4 Unknown
I Records, P.O. Box 68760, The law requires that the death certificate be executate has been signed by the attending physician and page 2 should be deteched for use as the burial-free	Completed	Prostate	Can	er				24a. Was perio	an autopsy primed?	availa	autopsy findings able prior to pletion of ceuse ath?
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Of Physical distribution	7: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of in (Month, L		ER/Outpatient 28b. Time of	3□ DOA Sinjung 28c. Injung Work	4 Unursing Ho	ome 5 ☐ Resi	denca 6 □Ot how injury occu		
ion nding ath. r: Afte	ation	1 Naturel 5 ☐ Pending investiga		Day Year)	Injury		k? Yes 2□No				
Division of Vital Re To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could no determin	ad 256. Place of I	njury - At ho etc. (Specify	ome, farm, stre	et, factory, offica		28f. Location (City or To	Street and Num vn, Stete)	ber or Rural R	loute Number,
Hospi 24 hou Funer staly fil	edicai	29a. Certifier TX Certifying (Check only one)	Physician: To the best aminer: On the bests	of examine	wiedge, deeth tion end/or Inv	occurred at the timestigation, in my of	ne, dete end placa, pinion, deeth occur	and due to the red at the time,	ceuse(s) and m dete and place	anner as stete and due to th	e ceuse(s)
o the	Me	29b. Signature and title of cartifier	and manner	stated.		29c. License	e number		29d. Date sign	ed (Month, Da	v. Year)
- 5 + 0		D'Almid	im Do.			AT O	48946		May 12	.,	
5	-	30. Neme and address of person wh	no completed cause of			Print)					•]
		O. Hwoding, S	101 E. U.	niver	sity po	arkway	Ballin	nore, r	MP, 2	1218	
Sta		31. Date filed (Month, Day, Year)	32 Regis	trails Signa	ture						

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State of Maryland / Department of Health and Mental Hygiene 0.7

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	Items10	f,2	2 5-15-97 FilmG747 W.H.per F/H		Certificate of	Death	Reg.	. No.	14944
	Physic /Medi Exami	cal	1. Decedent's Nama (First, Middle, Last) HENTY DWORKI 4a. Facility Nama (If not infitiation, give street and number) SINAI HOSPITAL	n		4b. City, Town, or Loc BALTIMO	2. Data of Death Month A ation of Death	Day Year 4c. County of Dec	3. Time of Death 7 0402 ath /A
3	Funeral Director		217-03-0498 15M 20F 7	yrs. last birt.	thday) If Undar 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, Ye AUG. 1,1	9. Bi	irthplaca (State or Foreign Country) ARYLAND
	death with the Maryland	ctor	Usual Residence of Dacedant 10a. State 10b. County 10c MARYLAND BALTIMORE	c. City, Town	or Location BALTI	MORE			10d. Insida City Limits 1 ☐ Yas 2 ☐ No
	23a or 28	ral Director	10e. Street and Number 2900 TAMARACK CT.		10f. Zip Coda 21209	2109	10g.	. Citizan of What C	Country?
Maryland 21215-0020	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heelth and Mental Hygiene. It let the Tarma 23s or 28s-4 show if I tem 27 is marked other than "natural", or itama 23s or 28s-4 show or other traumatic event, the Mexical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Navar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedant Ever Armed Forces? 1 ☑ Yas 2 □ No If Yas, Giva Yaar or Datas: Will Armed Yas or Datas: Will Armed Yas or Datas:	in U,S. WII	13. Was Dacedant of In If Yas, specify Cub 1 ☐ Yas 2 ☐ No		aify Yes or No- lican, atc.)	14. Race - Am Bleck, Wh Specify:	
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedant's Usual Occup (Give kind of work done	ation during most of workin	161	b. Kind of Busines	s/industry
121	within ne. hen *	Completed	Elamantary/Secondary (0-12) Collega (1-4or 5+)		PROPRIET	d)		EATING &	
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	Pages 1 and 2 nent of Heelth a int: If Item 27 Is iry or other tra		MRS. BESSIE DWORKIN (WIFE) 20a. Mathod of Disposition 1 MBurial 2 Cramation 3 Ramoval from State	0b. Place of cemetery	900 TAMARAC Disposition (Name of y, crematory or other pla	ce)	Data 200	c. Location - City o	
Baltimore,	permit. Pages 1 and Department of Heelth Important: If Item 27 any Injury or other tr once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	RUD		evinson &	BROS., IN		
			23e. Pen Finan II of distase, or complications that caused that should be the should be a should be should			STERSTOWN			MD 21208 Approximate
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	To the Hospital or within 24 hours effer To the Funeral Dir completely filled In	edical	29a. Certifiar 1 ☑ Certifying Physician: To the bast of my (Check only one) 2 ☐ Madicat Examinar: On the basis of axar and mannar stated.	knowladge, mination and	, daeth occurrad at tha tir Vor invastigation, In my c	na, date end place, ar prinion, daath occurred	nd dua to tha caus d at the tima, dete	a(s) and mannar a and place, and do	as stated. ua to tha cause(s)
	withir To th	Me	29b. Signature and little of certifier		29c. Licens	se number	29d.	Data signed (Mor	nth, Day, Year)
	/		> Lekumans		f.	140131		5/12/0	17
_	5		30. Name and address of person who completed cause of deeth	(Item 23a) (1 VE(/	Type, Print) VBERG	360,5	UITES	509	
	Sta Registr		31. Display (Month, Day Year) MAY 15 1991 June Jandson	Handel	L			l	

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State of Maryland / Department of Health and Mental Hygiene 4945 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death May 13, **Physician** Bertha Edna Duncan 11:00 A.M /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Baltimore City N/A Lorien Nursing Home 5. Sociel Security Number If Under 1 Yaar | If Undar 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Dete of Birth (Month, Dev. Year) Aug. 3, 1909 7. Aga (In yrs. last birthdey) **Funeral** Deys 1□M 200F Yrs Director 216-09-2363 Usual Rasidenca of Decedent death with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits *natural", or itema 23a or 28a-f ahow 1 X Yas 2 No Baltimore City Directo Maryland N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21206-1943 U.S.A. 4212 Belmar Avenue 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Reca - American Indien 11 Maritel Stetus filed within 72 hours after Hygiene. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3₺ Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry and Mental Hygiene. Elamentary/Secondery (0-12) Collaga (1-4or 5+) 6th Grade Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meidan Sumema) Be Pages 1 and 2 should be 1 nent of Health and Mental 1 Unknown Unknown Beltz Elizabeth Unknown George 19e. informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Uepartment of Health an Important: if Item 27 ia n any injury or other traum 906. Carroll I. Duncan/Son 4212 Belmar Avenue, Baltimore, Maryland 21206-1943 20b. Piece of Disposition (Name of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Steta 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Chesapeake Crematory 5/14/97 5 Other (Specify) Beltsville, Maryland 21. Signetury Funerel Service Lig 22. Nama and Address of Fecility John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 Homes ter the disease, or complications that caused the deeth. Do not enter the moda of dying, such as cardiac or raspiratory arrest, heart failure. List only one ceuse on each line. Approximete Intervel Batween Onset end Deeth **Physician** /Medical immediata Cause (Finel disease or condition resulting in death) **Examiner** Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death 8 Division of Vital Records, P.O. signed by d be detacl 1 Yes 2 No 3 Probably 4 Unknown ρ 24b. Were eutopsy findings aveileble prior to completion of causa of death? Completed 24e. Wes en autopsy 1 Yas 2 No 1 Yes 2 No certificate 25. Wes case referred exeminer? Be 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 8 28e. Dete of Injury (Month, Dey Year) 27. Menner Deeth Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affler 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, straet, factory, office building, etc. (Specify) after A 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and manner as steled.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated. 29e. Certifier o the howithin 24 hor route F Medical 29b. Signatur# and title of cartifier 29c. Licensa numbar 29d. Date signed (Month, Day, Yeer) D08358 me end eddress of person who completed cause of death (Item 23e) (Type, Print) 8903 HARFORD PIAS

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BAH MARY CHOIST SIgneture 32. Registrar's Signeture

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State of Maryland / Department of Health and Mental Hygiene

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16	18	e i	10e. Street and Number			10f.	Zip Code			10g. Citizen of V	What Country	y?
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200		by Funeral Director	11. Marital Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forcas? 1 □ Yas 2 X No If Yes, Give Yaer or Dates:				Hispanic Origin? (Span, Maxican, Puan Spacify:	pecify Yas or N to Rican, etc.)	Specify	e - Amaricar ck, White, et	c.
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director.	edicai	29e. Certifier 1 Certifying Ph (Check only one) 1 Medical Example 1	nysician: To the best of a ninar: On the basis of a and menner stete	xaminetic	riedge, deeth occurr on end/or investiget	ed et the ti	ime, dete and piece opinion, death occu	e, end dua to the urred et the tima	causa(s) and ma , date and piace,	end due to t	led. he cause(s)
	To the Total	Ardre Novalion in Do 8096				29d. Date signed (Month, Day, Year) MAY 11, 1997						
	10		30. Neme and address of person who	completed cause of dee	oth (Item	23e) (Type, Print)	123	- N.M.	AIN S	T. BEZ	MR	mollox
	Sta	ite	31. Dete filed (Month, Day, Year)			Pandella						

DHMH 16 Rev 6/95

4 m of 1997

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4947 Certificate of Death 1. Decedant's Nama (First, Middle, Last) 3. Tima of Death 2. Dele of Deeth Yaar MAY EMMA 09 97 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore City Joseph Richey Hospice 5. Social Security Number 6. Sax N/A If Undar 1 Yaar if Undar 24 Hrs. 8. Data of Birth (Month, Day, Aug. 5, 7. Aga (in yrs. last birthday) 9. Birthplaca (State or Foreign Days 1 ☐ M 2 🔀 F Maryland Yrs. 213-70-2288 86 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. insida City Limits Maryland N/A Baltimore City 1X Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U.S.A. 21213 2840 Mayfield Avenue 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No Was Dacedant of Hispente Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 1 Navar Married 2 Married 1 ☐ Yas 2 ☒ No Specify: 3 Widowed 4 ☐ Divorced White Yaar or Datas: Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elemaniary/Secondary (0-12) Collaga (1-4or 5+) 6th Grade 17. Fathar's Nama (First, Middla, Last) Own Home Homemaker 18. Mother's Name (First, Middla, Maidan Sumama) Warfield Kraft Florence E. Robert J. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 2890 Mayfield Avenue, Baltimore, Maryland 21213 Steven E. Fick/Grandson 20b. Placa of Disposition (Nama of camatary, crematory or other placa) 5/13/1997 ata 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Gardens of Faith Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatur of Funarai Sarvice Licensas 22. Nama and Addrass of Facility John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206 nter tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such es cardiac or respiretory arrest, by haart failura. List only ona causa on eech lina. Approximata Intarval Batween Onset and Deeth Immediata Causa (Final disaase or condition rasulting in death) Dua to (or as a consaquanca of): 23b. Did tobacco usa contribute to the cause of degli 1 Yee 2 No 3 Probably 4 Onknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad 1 Yas 2 VAK Yas 2 No 26. Placa of Daath (Check only one) axaminar' Othar: 4 Nursing Homa 5 Residance 6 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of injury (Month, Day Year) of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural

29c. Licensa number

29d. Data signed (Month. Dav. Year)

Examiner Sequantially list conditions, if any, laading to immadiata causa. Enlar Undarlying Causa (Disaasa or Injury that Initiated avants rasulting in daath) Last Physician/Medical å 985 b P.0 Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. Records, by Be Completed Division of Vital 25. Was casa rate and to me 2 100 Certification: Attec or Attending 5 Panding Invastigation death 1 Yas 2 Accidant Director: d in by the 6 Could not ba datagmined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 朝 4 \ Homicida To the Hospital o within 24 hours at To the Funeral D 29a. Cartifiar Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. Medical

State Registrar 29b. Signature and tifle of certifie

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

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permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, fire Media once.

Physician /Medicai

Examiner

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

by

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Day, Yaari

97-2589-510 AM COLLEEN GOI

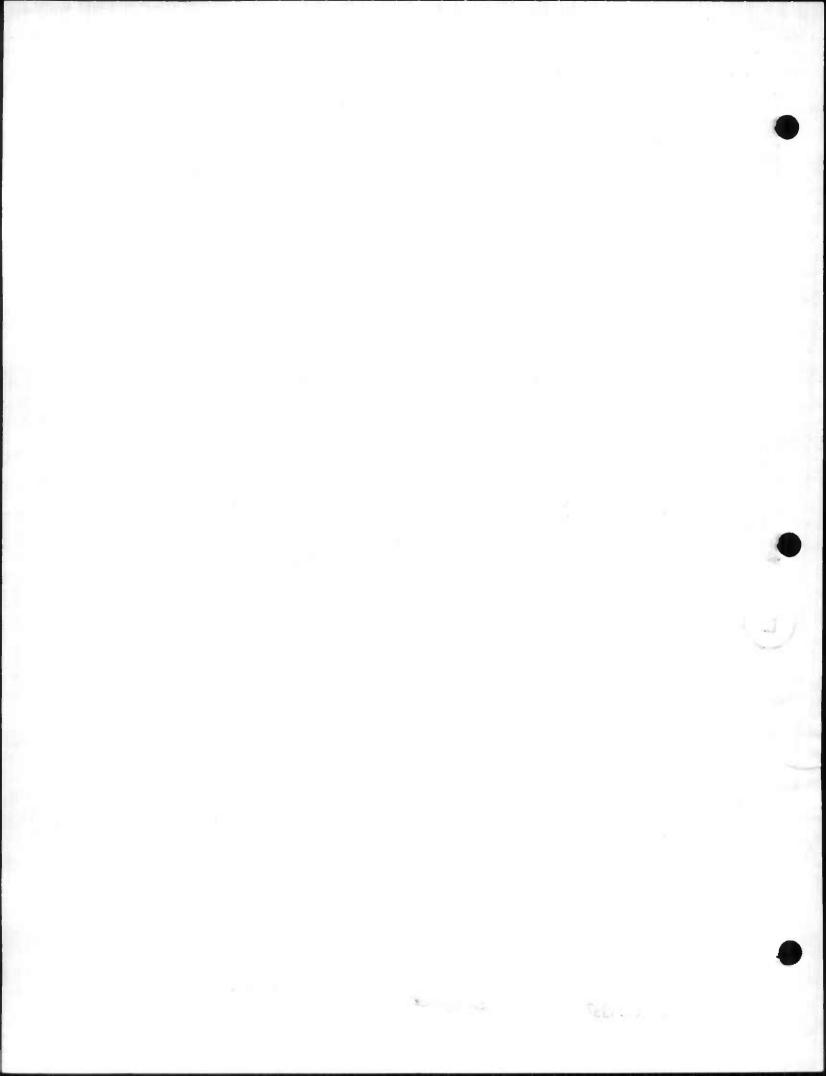
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State of Maryland / Department of Health and Mental H

ygiene	97	14941
Reg. No.	21	1474

	BURG		ITEM: 10e,19b,8 per F.H	H G-747 5-15-97 e	oh Certifi	cate of Death	Reg	g. No.	3/ 1	4948	
	Physic	an	1. Decedent's Neme (First, Middle, Last	" / //		1.116	2. Dete of Deeth Month	Dey	Yeer 3.	Time of Deeth	
	/Medi		A. C. W. M. M. M. M. M. M. M. M. M. M. M. M. M.	Colleen	1.	Goldberg	MAY 11	,1997		7:23 P	
À	Examir	ier	4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth BALTIMORE								
	Funeral Director		5. Sociei Security Number 6. Se			Under 1 Year if Under 24 Hinths Deys Hours Mi	s. 8. Dete of Birth	14 Year) /94/	9. Birthplace Country)	(State or Foreign	
Baltimore, Maryland 21215-0020	be filed within 72 hours after death with the Menjand tiel Hygiene. d other than "natural", or flems 23s or 28s-f show event, the Medical Examiner must be notified at	JO.	Usuel Residence of Decedent 10e. Stete 10b. County	Α.	ty, Town or Location	1				nside City Limits	
		Funeral Director	10e. Street and Number 84th	Street	7	0f. Zip Code 10028	10	g. Citizen of W	Vhet Country?		
		To Be Completed by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		Decedent of Hispenic Origin? 6, specify Cuben, Mexicen, Pus (es 2 No Specify:	Specify Yes or No- into Rican, etc.)		e - American In ik, White, etc.	ndien,	
			15. Decedent's Edu (Specify only highest gred Elementery/Secondery (0-12) / J. L. Graul		16e. Decedent's (Give kind life. DO N	S Usuel Occupetion of work done during most of w IOT use retired)	orking 16	8b. Kind of Bu	siness/Industr	у	
	Hygid Other		17. Father's Name (First, Middle, Lest)		06/1	- Employed 18. Mother's N	ame (First, Middle, Ma	aiden Sumem	e)		
	should be nd Mentel marked o		Charles R. 7	Thomas , Sr		Clar	a 5/00	we			
	2 shou and M is mar		19e. Informant's Name/Relationship (T)	ype, Pnint)	19b. Meiting Ad	Idress (Street and Number or I	Rurel Route Number,	City or Town,	Stete, Zip Cod	le)	
	and 2 eelth a n 27 is		Dr. David C. Gol	dberg-Husbana	114 E		york, K	lew 9	ork.	10028	
	permit. Pages 1 and 2 should Department of Heelth and Mer Important; if Item 27 is marke any Injury or other traumatic once.		20a. Method of Disposition 1 Burial 2 Cremetion 3 F 4 Donetion 5 Other (Specify)	Removel from State	Place of Disposition cometery, cremeto.	Yor other place) Morial Park	!	Oc. Location - Randa	ellstuc	stete un, md	
Bal	permit. Departm Importal any Inju		21 Shinature of Funeral Service Licens	luce V	- yar	me end Address of Fecility F. H. W.A. 300 W.A.	tockerch An	enue	Baltin	21215	
Ļ	Physician		23 A rt1. Enter the disease, a complete the	licetions thet caused the deet ne ceuse on eech line.	h. Do not enter th	mode of dying, such es cerdi	ec or respiretory erres	it,	inte	proximete ervel Between set end Deeth	
	/Medical Examiner		Immediate Cause (Final disease or condition	Disse	ection of	Aorta					
	Examiner	-	resulting in death) Due to (or es e consequence of):								
-4 "	msit	Examiner		b		2-0			I		
Box 68760-1	sicial and burial-ira		Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events Due to (or es e consequence of):								
	aath certifica attending phy I for use as th	n/Medical	resulting in deeth) Lest	d	as a consequenc	e oi).					
	daath ce ne attendii ed for use	Physician/M	Pert it. Other significant conditions con	ntributing to deeth but not res	ulting in the under	ying cause given in Pert I.	23b. Did tob	acco usa cor	tribute to the	cause of death?	
Division of Vital Records, P.O.	iras that the death cer signed by the attendir d be detached for use	by Phy						8 2□No	3 Probabiy	y 48Unknown	
	Tha law requate hes been page 2 shoul	Completed					24e. Wes an perform		aveileb	utopsy findings le prior to ition of ceuse h?	
							12 Yes	2 □ No	1√2 Yes	s 2 No	
	siclan: The certificate rector, pag	o Be	25. Wes case referred to medical exeminer?	Hospitel:		Other:	eeth (Check only one,				
	this raidi	ation: To	1 X Yes 2 No 27. Manner of Deeth 1 Deeth 2 Accident 5 Pending investigation	28e. Dete of Injury (Month, Dey Yeer) 28b. Time of Injury 28c. Injury et Work? M 1 Yes 2 No			1	ome 5 □ Residence 6 □ Other (Specify) 28d. Describe how injury occurred			
	rs after death. Is after death. In Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined	286. Piece of Injury - At nome, ferm, street, factory, office 28f. Location				n (Street end Number or Rurel Route Number, Town, State)			
	To the Hospital within 24 hours of To the Funeral Completely filled	edical	29a. Certifier (Check only one) 1 Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end manner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and manner steted.								
	With To th	Σ	29b. Signature end title of certifier 29c. License number					29d. Dete signed (Month, Dey, Year)			
	5		30. Name and address of person who completed cause of death (Item 23e) (Type, Print)						2,1997		
			Dennis J. Chu	ite, MD 11	1 Penn	Street, Bal	timore, N	4aryla	and_21	201	
	Sta Registr	-	31. Dete filed (Month, Day, Year) MAY 1 5 1997	Little Della Ser Sha	HALL S			-			

Registrar



State of Maryland / Department of Health and Mental Hygiene

	Item4c	5-	15-97 FilmG747 W.H.Per	F/H		rtificate of	Death		leg. No.		4949
	Physic							th Day	Vear	Time of Death	
	/Medic Examin	-	As Fredholms (Marchaell As an annual As an a								
			5. Sociel Security Number 217-18-0262 6. Sex 1 M 2 F 83 7. Age (In yrs. last birthday) Nonths Days Hours Min. 8. Date of Birth (Month, Day, Yaar) SEPT. 11,1913 MARYLAND							(State or Foreign	
			Usuai Residenca of Decedent 10e. State 10b. County	10c.	City, Town or L	ocation				10d.	Inside City Limits
	88-1 sl		MARYLAND N/A]	BALTIMORE	E				1∑ Yes 2□No
	permit. Pages 1 and 2 should be filed within 72 hours effer death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-4 show any liqury or other treumetic event, the Medical Enginer training to notified at once.		10e. Street and Number			10f. Zip Code	01000		log. Citizen of V	/hat Country?	
20			7203 BROOK CREST 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Was Decedant Ever in Armed Forces? 1 ☐ Yes 2 ☐ Xo If Yes, Give		Was Decedent of If Yes, specify Cul	21208 Hispanic Orlgin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)	USA 14. Race Blec Specify	a - Amarican I k, White, etc.	
21215-0020			15. Decedent's Edu (Specify only highast grad	a completed)	(Give	edent's Usual Occu e kind of work done DO NOT usa ratin	during most of wor	king	16b. Kind of Bu		HITE
212			Elementary/Secondary (0-12)	College (1-4or 5+)		MANAC	SER		LADIES	CLOTH	ING
pug			17. Fathar's Name (First, Middle, Last)					ne (First, Middle,	Maiden Sumam	e)	
Maryland			LTPPMA 19a. Informant's Name/Relationship (Ty		T	KOFF	ANNA at and Number or Ru	and Davida Muselia		ACOBSON	
			MR. ALBERT O. GR								,
Baltimore,			20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cra	osition (Name of imatory or other pla YOUNG ME	ace) ENS	Dete 5-15-97	20c. Location - BALTIMOR		State
Balt			21. Signature of Funerel Service Licensee 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208								
	100	Г	23a. Part Enterthe disease, or complete shock or heart failura. List only or	ications that caused tha d na causa on each line.						Ap Inte	proximate arval Batween
	Physician /Medical Examiner	ner	Immediate Cause (Finel disease or condition resulting in death) a. Sepsils 1 week								
				Due t	o (or as a conse	equenca of):					
,0	as the ded	Medical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying								
x 68760,			Cause (Disease or Injury that Initiated events resulting in death) Last								
Вох					later to the			00h Dida			44.00
S, P.O.			Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobe						ee 2□ No		y 4 Unknown
Records,								24a. Was a perfor		evailat	autopsy findings ble prior to etion of cause th?
								1□ Y	es 20 No	1 □ Y€	es 2 No
Vita			25. Was case referred to medical examiner?	lospital:			hor	eth (Check only or			
ō			1 ☐ Yes 2 No	28e. Date of Injury	ER/Outpatie	IN 3L DOA		ome 5 Resid			
ion			1 Natural 5 ☐ Panding 2 ☐ Accident invastigation	(Month, Day Year	28b. Time of 28c. Injury at Work?			200.200.000.000.000.000			
Division of Vital			3 Sulcide 6 Could not be determined	At home, farm, street, factory, office 28f. Loca				tion (Street and Number or Rural Routa Number, or Town, Stata)			
			29a. Cartifier (Check only one) 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, data and place, and due to tha ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and manner steted.								
			29b. Signature and title of certifiar 29c. License number AS24023210A.				29d. Date signed (Month, Day, Year) D9030 MAY 13 1997				
			30. Nama end addrass of person who co	empleted causa of daath (, Print)	Dor	alhas	Dak-		
	Sta	te	Sinai Hosp 31. Date filed (Month, Day, Year)	12 Regulars Sa		imore	DOY	OTITE	2005	XV 1	

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State of Maryland / Department of Health and Mental Hygiene Item 5 Per FH Film G748 6-25-97 rja 4950 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death **Physician** Month Year JEAN H. GANO MAY 12,1997 /Medical 10:45 p 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Daeth **Examiner** 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Undar 1 Yaar If Under 24 Hrs.
Months Deys Hours Min. Social Security Number 82-42-1636 6. Sex 1 □ M 2 万 F 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Deys 182-42-1836 Director Yrs. Pennsylvinia 27, 1955 Nov. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. fnslda City Limits Director 1 ☐ Yes 2√2 No New Jersey N/A Summit 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 24 High Street 07901 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Yes 2 ▼ No Specify: Baltimore, Maryland 21215-002(þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 4 years Homemaker Own Home permit. Pages 1 and 2 should be thed Department of Health and Mental Hygi Important: If Item 27 is marked other 17. Fether's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Meidan Sumama) Be William Hudson Dorothea tenCate 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) Rhett Gano (husband) 24 High Street Summit, New Jersey 07901 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 1 Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 0 5-14-97 Green Mount Crematory Baltimore, Maryland 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Mitchell-Wiedefeld Home 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximeta Intarval Between Onset and Deeth **Physician** /Medical Immedieta Cause (Finel · MALIGNANT PLEURAL EFFUSION diseese or condition rasulting in daeth) Examiner Examiner BREAST CANCER EARS METASTATIC The law requires that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if eny, laading to immedieta causa. Enter Underlying Ceusa (Diseese or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Dua to (or es e consaquance of): attending | Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No á 3 Probably 4 Unknown METASTATIC PISEASE signed b Records, by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Was en autopsy performed? Completed WNG, LIVER, BONE, SKIN peeu page 2 1 Yas 1 ☐ Yes 2 XNo this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case refarred to madical axaminer? Be 26. Place of Deeth (Check only ona) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA s after death.

I Director: After this id in by the funeral d 27. Menner of Deet 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Dascribe how Injury occurred 1 Netural 5 Panding Investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Straat end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleide 29a, Cartifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, deta and plece, end due to the causa(s) and menner es steted.
2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the causa(s) end manner stated. completely 29b. Signature and the of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) RES-000 rson who completed causa of death (Item 23e) (Type, Print) LAURA WIDNELL, MAD

State Registrar

HERING

32 Finding rar's Signature

was to

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson Gilchrist Hospice Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Nov. 3, 1927 Birthpleca (State or Foreign Country) 220-20-5682 Months Days 1 M 2XX Hours 69 Yrs. Maryland Usuat Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore City 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 338 Folcroft Street 21224 United States Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2**X**No If Yes, Give Year or Dates: 1 ☐ Yes 2XXVo Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Real Estate 12 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Clarence W. Irons Violet M Eierhart 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Gillespie/Son 3419 Orlando Ave., Baltimore, MD 21234 20b. Placa of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Green Mount Crematory 5-15-97 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA- Stephen D. Lohrmann, P.A. 8717 Green Pastures Drive, Baltimore, MD 21286 ese, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, e. List only one cause on each line. Approximate intervat Between Onset and Death Immediate Cause (Finel disease or condition resulting In death) SMALL cell Covainom of the Lung Due to (or es a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed?

Physician /Medical Examiner

permit. Pages 1 and 2 and 2 and 2 and 2 and 1 an

Physician

/Medical

10a. State

MD

Director

Funeral

by

Completed

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Examiner

Funeral

Director

28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examines must be not the discontinuous.

Baltimore, Maryland 21215-0020

the Maryland

The law requires that the death P.O. Records, 8 page 2 should Vital

of

Division

certificate or Attending Physician: director, To the Hospital or Attending Physi within 24 hours after death. To the Funeral Director: After this (the funeral filled in by completely Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Physician/Medical Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. þ Completed Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HarInjury at 28d. Describe how injury occurred 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of tnjury (Month, Day Year) 27. Menner of Death Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and

29c. License number

29d. Date signed (Month, Day, Year)

N. Charles St. Bolts, and 20204

1 ☐ Yes 2 ☐ No

State Registrar

Medical

32. Registrar's Signature

7981 - 1417

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

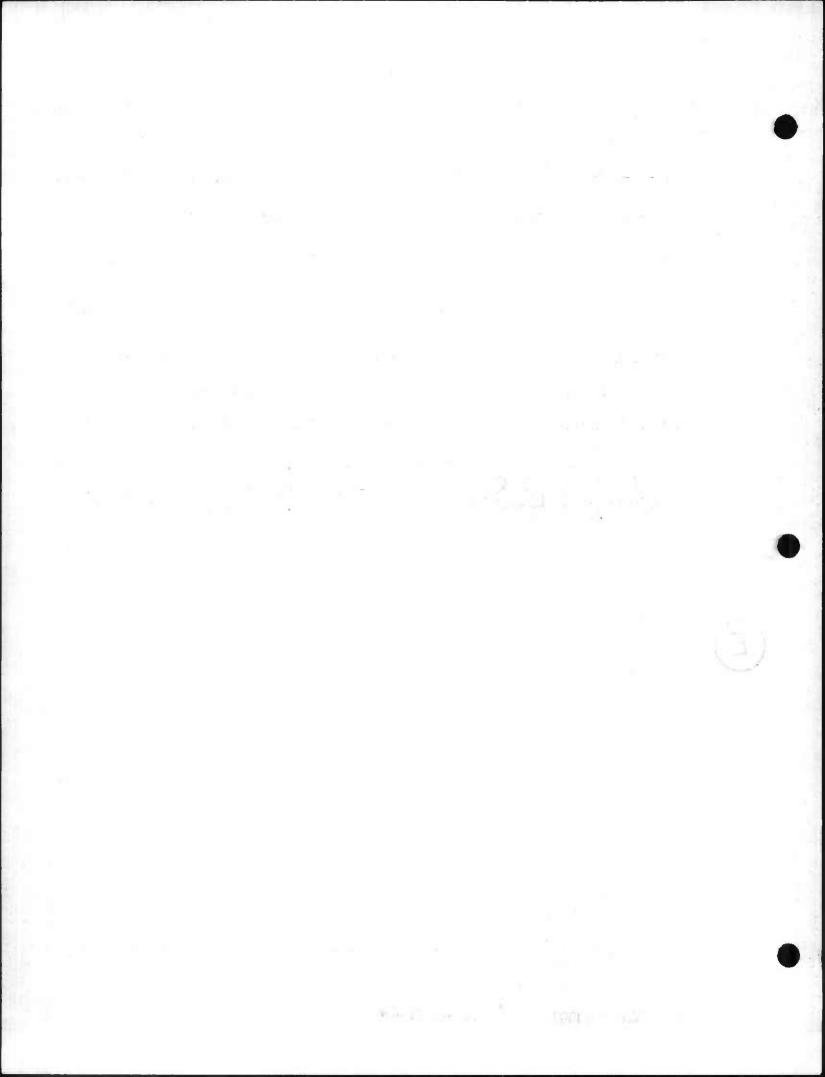
State of Maryland / Department of Health and Mental Hygiene

14952 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Year Eugenia Hernandez May 1997 0502 am. 13 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Johns Hopkins Bayview Medical Center Baltimore 5. Soclei Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Hours 1 M 2 □ F Director 217-26-3670 Jan. 1,1893 Philippines 104 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Llmits 7 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, he Medical Examinar must be notified at Director Maryland N/A Baltimore City XX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 619 Savage Street 21224 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Haelin and Mental Hygiene. Important: If Nem 27 is marked other than "natural; or the any Injury or other traumatic event, as Montal Examples. 1 √ Yes 2 □ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No þ Specify 3 Widowed 4 □ Divorced WWII Asian Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Years Ches Restaurant 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Not Known Not Known 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy L. O'Conner/Stepdaughter 619 Savage Street Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 ☐Other (Specify) Hilltop Service Corp. 5/15/1997 Towson, Maryland 22. Name and Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature # FA eral Service License 7922 Wise Ave. Dundalk, Maryland 21222 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximete Intervel Betw Onset end Death **Physician** /Medical Immediate Cause (Final SEPSIS 1 day disease or condition resulting in death) Examiner Due to (or es e consequence of): Examiner 3 day PNELIMONIA Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): 68760 Physician/Medical Due to (or as a consequence of) Box (P.O. 1 Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings evallable prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? 1□ Yes X No 1 Yes 2 □ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Netural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. Medical 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mathery . Walter M.D. N2638 May, 13, 1997 40 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hospital, Tower 110, Baltimore Maryland. 31. Date filed (Month, Day, Year) 32. Registrer's Signature Alkie Veridoon-Randelle MAY 1 5 1997 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4953 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 5 JOSEPH REGINALD HUNT 1997 1:00AM 4a. Fecliity Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death (HOME) 1606 CHESAPEAKE AVE BALTIMORE N/A If Undar 1 Year Months Deys If Undar 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplece (State or Foreign Country) MD 1∭0 M 2□ F 217-26-2882 66 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A 1 No Yes 2 No BALTIMORE 10e. Street and Number 10f Zin Code 10g. Citizen of Whet Country? 1606 CHESAPEAKE AVE. 21225 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritai Stetus 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bieck, Whita, etc. 1 Never Merried 2 Married 1 X Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 X No AFR. AMERICAN Specify. r Yes, Give Yaar or Dates: 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) LABORER CONSTRUCTION 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) JOSEPH R. HUNT INEZ HUNT 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) INEZ HUNT (MOTHER) 1600 MT. ROYAL AVE. BALTO. MD 21217 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VA CEM. 5/15/97 OWINGS MILLS MD 21. Signeture of Funeral Service Licansee ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217 23a. Pert1. Enter the disease, or complications that caused shock, or heart feliure. List only one cause on each lin deeth. Do not antar tha mode of dying, such es cardiec or raspiretory arrast, Approximeta Intervel Between Onset end Deeth Immediate Ceuse (Final diseasa or condition resulting in deeth) . Metastatic Adeno coscioned the Lung moo Due to (or es e consequence of): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in daeth) Last Due to (or es e consequenca of): Due to (or es a consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contributa to the cause of death? 1 Tos 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings 24e. Wes en eutopsy performed? aveilable prior to completion of cause of deeth? 1 Yas 2 No 1 Yas 2 No 25. Was case referred termedical examiner? 28. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

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28a-f show

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traumatic event, the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death v Depertment of Health end Mental Hyglene. Important: If item 27 ie marked other than "natural". cr Hamplinty or other traumatic even.

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Physician/Medical Examiner þ Completed page 2 s Be

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Records, P.O. Box Division of Vital or Attending death. Director: n 24 hours efter des Ne Funeral Director pletaly filled in by th Hospital To the Hosp within 24 hor To the Fune completaly fi

> State Registrar

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4 Homicide 29e. Certifier (Check only one) 29b. Signature and the of certifier

1 Yes

27. Menner of Deeth

1 Neturel

2 Accident

3 ☐ Suicida

5 Pending investigation

6 ☐ Could not be determined

Hospitei: 1 Inpatient 28e. Dete of injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

to the courtifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) and menner steted. 29c. Licapse number

29d. Data signed (Month, Day, Year)

tress of person who completed cause of deeth (Hem 23e) (Type, Print) Crain Highway,

Q, De 31. Deta filed (Month, Dey, Yeer)

SILINO

MAY 1 5 1997



Secretary Secretary

Piease Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

4954 Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Data of Death 3. Time of Death ADELE KOKE C. **Physician** MAY 11, 10:45am 1997 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Fecility Neme (If not institution, give street end number) Examiner ROLAND PARK PLACE BALTIMORE 5. Social Security Number If Under 1 Year | If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) JULY 23,1900 Birthplace (Stata or Foreign Country)
 MD 7. Age (In yrs. lest birthday) **Funeral** 056-38-5824 1 M 2 DE Months Deys Hours 96 Yrs. Director Usuel Rasidance of Decedant death with the Maryland 10b. County 10a Stata 10c. City, Town or Location 10d. insida City Limits or 28a-f show traumetic avent, the Medical Examiner must be notified at MARYLAND BALTIMORE N/A Director 1 Yes 2 No 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Coda 830 W. 40th ST. 21211 USA **Нета 23** Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ②No If Yas, Giva Yaar or Dates: 11. Meritei Status Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxicen, Puarto Ricen, atc.) 14. Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours efter o Department of Health and Manial Hyglena. Important: if Itam 27 is marked other than "natural", or item any injury or other traumatic avent, the Medical Experience. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 🛣 No Specify: Specify by 3 Widowed 4 Divorced WHITE Completed 16a. Decadent's Usuei Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) HOMEMAKER OWN HOME 17. Fathar's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) FRANK CAHN THERESA HAMBURGER 19e. informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) MR. JOHN HENRY KOKE (HUSBAND) 830 W. 40th ST. BALTIMORE, MD 21211 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 X Cramation 3 ☐ Ramovel from State HILLTOP SERVICE CORP. 5-12-1997 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Easthinson & BROS., INC. 21. Signatura of Funarei Sarvice Licensee devinor 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or compilications that ceused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each line. Approximata Onset end Deeth **Physician** Immediata Ceuse (Final diseesa or condition rasulting in daath) /Medical Cerebral hemorahay Examiner Dua to (or as a consequence of): Physician/Medical Examiner atheroschertic disence ng physician end as the burial-transit The lew requires that the death certificets be executed Sequentially list conditions, if any, laading to immedieta ceuse. Entar Underlying Cause (Disaesa or Injury that initiated evants Due to (or as a consequance of): Box 68760 hypertonsion Dua to (or as a consequence of): rasulting In daath) Last P.O. 1 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Ware autopsy findings aveilabla prior to complation of causa of death? Completed 24a. Was an autopsy peen has 2 No 1 Yas 1 TYas 2 No Aftar this certificate Division of Vital Be 25. Was cesa rafarred to medical 26. Placa of Death (Check only ona) examinar? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) hospice 10 28a. Data of Injury (Month, Day Year) 27. Mannar of Death To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th complately filled in by the funeral 28d. Dascribe how injury occurred 28b. Time of Certification: 1 Netural 2 Accident 5 Panding injury 1 ☐ Yas 2 ☐ No Investigation 6 Could not be datermined 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, Steta) Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 197Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and dua to the causa(s) and mannar as steted.

2 Medical Examinar: On the basis of examinetion and/or invastigation, in my opinion, daeth occurred at the time, date and place, and due to the causa(s) 29a Certifier Medical end menner stetad. 29d. Data signed (Month, Day, Year) 29c. Licansa numbar 29b. Signature and Into 0 19914 30. Name end address of person who complated cause of death (Itam 23a) (Type, Print) T. Fine LUTTICHULLE AB 2109) mb 2328 WJUPPA NO State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4956 Certificate of Death 1. Decedent's Name (Firşt, Middle, Last) 2. Date of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Beath 4c. County of Death altimore 1 lasles Datimore Undar 24 Hrs. 8. Date of B 060 5. Social Security Number If Undar 1 Year If 7. Age (In yrs. last birthday) Sex 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) 1 □ M 2 XF Months Days Hours Yrs. 216-01-9584 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 Yas 2 □ No Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5800 Greenhill Avenue 21206 U.S.A. 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Naver Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 □ Divorced Yaar or Dates: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker 6th Grade Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Unknown Cerko Anna Unknown Lecardo 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5800 Greenhill Avenue, Baltimore, Maryland 21206 Veronica Schlimm/Daughter 20b. Plece of Disposition (Name of cametery, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Buriai 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 5/14/97 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ine of Funaral Servica Licansee 22. Name and Addrass of Facility John C. Miller, Inc. uanta 6415 Belair Road, Baltimore, Maryland 21206 thomas Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, or heart failure. List only one cause on each lina. Approximata Intervel Between Onsat and Death Immediate Cause (Final disease or condition resulting in deeth) tailun respiration Due to (or as a pensequanca of): Due to (ones a consequence of): Stag Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last hypercarbic Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cancer 24e. Was an eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Rasidenca 6 Mothar (Specify) NOSPICE

Physician /Medical Examiner

Physician /Medical

Examiner

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Peges 1 and 2 should be nent of Health and Mental

of Health and Nitem 27 is mail

permit. Peges
Department of H
Important: If ite
any injury or ot

Maryland 21215-0020

Baltimore,

burial-tra attending physician for use es the buria Box The law requires that the death igned by the a P.0. signed Division of Vital Records, should should has certificate l or Attending Physician: after death.
Director: After this certifica the

Physician/Medical þ Completed Be Certification: To 29e. Certifier Medical

Examiner To the Hospital of within 24 hours a To the Funeral D completely filled

1 Yes 2 No 27. Manner of Death

1 Naturai 2 Accidant 3 Suicida 4 Homicide

(Check only one)

5 ☐ Pending invastigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

Hospital

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Lutherville

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) end menner es stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifles 1 an remose

D40508

Ste 320

29c. License number

29d. Dete signed (Month, Dey, Year)

Mil

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) York 1205

Ra

State Registra

32 Registrar's Signatura whia Davidson

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death Month aczorous 4b. City, Town, or Location Death 4e. Facility Neme (If not institution, give street end number) 4c. County of Death Good Samaritan Hospital Baltimore N/A If Under 1 Year if Undar 24 Hrs. 5. Sociel Security Number 6. Sax 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1**/3**M 2□ F Deys Hours Yrs. 215-14-8139 78 04/10/1919 Maryland Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of Whet Country? 21231 2217 Bank Street USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indlen, Biack, White, etc. 1 ∰Yes 2 No If Yes, Give Yaar or Dates: 43 – 45 1 Nevar Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Plumber Industry/Corp. 4 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Frank Kaczorowski Francis Urza 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Spouse Barbara V. Kaczorowski 2217 Bank Street Balto. MD. 21231 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriai 2 Cremetion 3 Ramoval from State 4 Donetion 5 Other (Specify) 5-17 Louden Park Cem. Baltimore MD 22. Name end Address of Fecility David J. Weber Funeral Home 401 S. Chester St. Balto. MD. 23e. Perli. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. ADDITION OF THE PROPERTY OF THE PROP immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last Dua to (or as a consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? No No 1 Yes 3 Probably 4 Unknown

Physician /Medicai Examiner

Baltimore, Maryland 21215-0

P.O. Box 68760,

Division of Vital

Hospital Mours Funeral

24 To the 1 within 2 To the I

> 2 IVA

Pages 1 and 2 should be nent of Health and Mental I tem 27 is marked of

ò Department Important: If

Physician

/Medical

Examiner

Director

Funeral

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Completed

10a. Stete

MD

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Director

physician and the burial-transit Physician/Medical 0 signed by the at d be datached for þ Completed paga 2 director. Be 2 funeral Certification: pital or Attending curs after death. aral Director: Aft

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24e. Wes en eutopsy performed?

24b. Were autopsy findings aveilable prior to completion of ceuse of deeth?

25. Wes case referred to medical exeminer? 1 ☐ Yes No

26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpetient 3 DOA 28b. Time of 28d. Describe how injury occurred 28c. injury et Work?

1 ☐ Yes 2 ☐ No

27. Menner of Deeth 5 Pending investigation 1 Naturel 2 Accident 3 Suicide 6 Could not be determined

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stete)

29a. Certifier

4 Homicide

29b. Signatur® and title

1 Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceusa(s) and manner as steted 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s)

29c. License number

29d. Date signed (Month, Dey, Year)

State Registrar

Medical

with English C. S. ...

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.7

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		1 December Name (First Middle Lea	A)		Certificate of	Death		eg. No.		1900
Physicia		Decedent's Neme (First, Middle, Las	Virginia	Ellen	Leone		2. Dete of Deat Month May 9,	Dey 1997	14	ime of Deeth : 30 PM
/Medic		4e. Fecility Neme (If not institution, give	street end number)			4b. City, Town, or L		4c. County		
Examin	er	2445 Fairway				Dundal			timore	
Funeral		5. Social Security Number 6. Se		rrs. last bin	hday) If Under 1 Year	If Under 24 Hrs.	8. Dete of Birth			Stete or Forei
Director		217-18-0182 Usuel Residence of Decedent	□ M 212 F 80	-	Yrs. Months Days	Hours Min.	Feb. 7,	1917	9. Birthplace (S Country) Maryla	nd
land w		10e. State 10b. County	10c.	City, Towr	or Location				10d. ins	side City Lim
Ba-f sh	Director		timore			Dundal				Yes 2
h with the		10e. Street end Number 2445 Fairway			10f. Zip Code	21222	10		What Country? Ld State	s
deat	Funeral	11. Marital Status	12. Was Decedent Ever in	n U,S.	13. Was Decedent of	Hispenic Origin? (Sp	ecify Yes or No-		e - American Ind	lien,
urs e	þ	1 Never Married 2 Married 3 🖾 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes:		1 ☐ Yes 2 D(No	Hispenic Origin? (Specify Yes or No- en, Mexican, Puerto Rican, etc.) Specify:		Bleck, White, etc. Specify: White		te
"natural",	Completed	15. Decedent's Ed	ucation	16a.	Decedent's Usuei Occu	pation	vina	16b. Kind of B	usiness/Industry	
within / ene. than "r	npie	Elementary/Secondery (0-12)	College (1-4or 5+)		(Give kind of work done life. DO NOT use retire	a during most or worr ad)	ang			
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	Be	17. Fether's Name (First, Middle, Last)					e (First, Middle, M		ne)	
	2	Michael Beck				Ada	Unknow	n		
az snould h and Mer 7 Is marke traumatic		19a. Informent's Neme/Reletionship (7			Mailing Address (Stree)
205		Rosalie M. Forre			914 Queens		lk, Mary	land !	21222	
0 0		20e. Method of Disposition 1 ঐBurlal 2 ☐ Cremetion 3 ☐	Pomoval from State	b. Place of cemeter	Disposition (Neme of y, cremetory or other ple	ece)	Dete	20c. Location	City or Town, St	ete
reges ment of ant: If its ury or o		4 Donation 5 Other (Specify) (Dak L	awn Cemeter	u 5/13/1	997	Balti	nore. MI)
Department of Important: If any injury or once.		21. Signeture of Funeral Service Licens			22. Neme end Addr Duda∽Ruck	ess of Fecility Funeral	Home of			
			lications that caused the	eath Dor	1922 Wise	Ave. Du	ndalk, M	arylan		
		23a. P 111. Enter the disease, or comp shock, or heart feilure. List only of	ne ceuse on eech line.	eath. Do r					Onse	oximete rel Between I end Deeth
hysician /Medical		Immediete Cause (Final	(idam	1111	a Mule.		Link	11	A-	
xaminer		disease or condition resulting in death)	e. Carra	ucu	/ //rulla	eenary	majin	ground	a one	154
			Due to	o (or es e o	onglaggence of):	eenany	/	/		
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and I-trar	xan	Sequentially list conditions, if env. leading to immediate	Due to	o (or es e	conseque (co/cf):					
g physician and as the buriel-transit	<u>8</u>	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events	C		I.					
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igned by the attendin be detached for use	Physician/N									
Ine law requires met me deam ate hes been signed by the atter page 2 should be detached for to	sic	Pert II. Other eignificant conditions co	ntributing to death but not	resulting in	the underlying cause gi	iven In Pert I.	23b. Did to	bacco uee co	ntribute to the c	ause of dea
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bed be	b								T	
been si should	Completed						24a. Was e		24b. Were eut	prior to
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ate he	0						1 □ Y€	s 2. No	1 ☐ Yes	2 No
	Be	25. Wes cese referred to medical				26. Place of Dee	th (Check only on	e)		
	10E	exeminer? 1 ☐ Yes 2,20 No	Hospital: 1 ☐ Inpatient 2	ER/Ou	petient 3 DOA Ot	ther: 4 Nursing He	ome 5 Reside	nce 6 DOth	er (Specify)	
eral di	<u> </u>	27. Manner of Deeth	28e. Date of Injury	28b. T	ime of 28c. Inju	ury et	28d. Describe ho			
leath. lor: After thi the funeral	흥	1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Dey Year) Ir		ork? ∐Yes 2∐No				
or death. octor: After by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Plece of Injury - A	I home, fe	m, street, factory, office					e Number.
after Olre	E E	4 ☐ Homicide determined	building, etc. (Spe	ecify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town			
	edicai C	29a. Certifier (Check only one) 12 Certifying Phy 2 Medical Exami	alcian: To the best of my iner: On the basis of exem	nowledge	death occurred at the ti	ime, dete end piece, opinion, deeth occur	end due to the ce	ouse(s) end me ete and place,	enner es steted. and due to the c	euse(s)
m the	ğ	29b. Signature end title of certifier	end manner stated.		29c Licen	ise number	26	od Date sione	d (Month, Dey, Y	(oar)
8 7 €		> they	nuca		Λ.	0613	,	1-12	-97	our)
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10		30 Nume end eddress of person who c	ompleted ceuse of deeth (I	tem 23a) (Type, Print)	TERAM	Un Ril	2	1208	
10		KAFAEL PENE	ELMERA	17	Type, Print)	STERSTON	on Rel	2	1208	
State Registra		30 N) me end eddress of person who of APAPL PM 31. Dete filed (Month, Day, Year) MAY 1 5 1997	ompleted cause of deeth (I 2 ME RA 32. Registrer's Sig Fulic Vavidor	gnature	Type, Print)	STERSTON	on Rel	2	1208	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

11,050

					Ce	rtificate	of Death	7		Reg. No.)	14303
		1. Decedent's Name (First, Middle,	Last)						2. Data of De		Vee	3. Tima of Death
Physic /Medi		MARGARET			1000	51NS			MAY	10 , /	Year 997	1920
Exami		4a. Facility Nama (If not Institution,		mber)				own, or Loc	ation of Deat		ty of Death	
		SINAI MOSP	ITAL				BA	LTIM	ORE	N/A	Ł	
Funeral			6. Sax 1 ☐ M 2√2√F	7. Age (in yrs. i		If Undar 1 \ Months D	aar If Under		8. Data of Bi (Month, Di		9. Birth	placa (Stata or Foreign intry)
Director		213–12–2433 Usual Residence of Decedant	- JEX	84	Yrs.				Jan. 2	27,1913	MD.	
b and		10a. Stata 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
the Maryland	Ö	MD. N/A		Pil	kesvil	le						1 Yes 2 No
r 28s	9	10e. Street and Number				10f. Zip Co	da			10g. Citizen of	What Cou	untry?
death with the Maryland ims 23a or 28a-f ahow fundst be notified at	Funeral Director	7146 N. Alter St	reet			2120	7			U.S.A.		
death	ner	11. Maritei Status	12. Was Deci	edent Ever In U,	S. 13.	Was Deceden	of Hispanic Or Cuben, Mexica	rigin? (Spec	ify Yas or N	o- 14. Ra		ican Indian,
72 hours after natural; or he	þ	1 ☐ Nevar Married ♣ Marrie 3 ☐ Widowed 4 ☐ Divorced		2 XXV0		1 ☐ Yes 2√∑			ican, etc.)		ack, Whita, ify: Blac	
d within 72 hours at giene. If than "natural", or the wedical Exam.	Completed	15. Decedent's (Specify only highest	s Education grade completed)		(Give	dent's Usual C kind of work of	one durina mos	st of working	9	16b. Kind of E	Business/Ir	ndustry
within ene. then	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use r	etired)			Domesti		
e filed vill Hygie other t	ပိ	High School 17. Father's Name (First, Middle, L.	ast)		Homen	aker	18 Moth	er's Name	/First Middle	, Maiden Suma		
0 0 0	Be C	John Wilson Bri							ffers			
s 1 and 2 should ! Health and Mer tem 27 is marke other traumatic	2	19a. Informant's Neme/Relationsh		hachand	19b. Maili	ng Address (S	treet and Numb	per or Rural	Route Numb	per, City or Town	n. State. Zi	in Code)
		Ernest F. Loggin		iusbariu		-				lle, MD.		
Hem Hem		20a. Method of Disposition		20b. P	iaca of Dispo	sition (Name	of		Date	20c. Location		
age ant c y or		1 Surial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (Sp.		State		natory or otha	, ,	eterv	Mav14	Laurel	MD.	
permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L		PICE						neral Ho		
Depa Impo Impo Inpo		Herbert	F E. V	retter	- 25	01 Gwy	nns Fal	lls PK	WY Ba	ltimore	, MD.	21216
		23a. Part ¹ . Enter tha disaase, or c shock, or heart failure. List o	omplications that only one cause on e	aused the death each line.	n. Do not en	er the mode o	f dying, such as	s cardiac or	respiratory a	arrest,	- 1	Approximate Interval Between Onset and Death
Physician /Medicai		Immediate Cause (Final					11					
Examiner		disease or condition resulting in death)	a. fr	TRA CE			HEM	ORRI	MAGE			12 Hour:
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b d ansit	Examiner	Convention the that any divine	b. H)	IPERT	r as a consec						1	SUT YR
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- 8 No. 8	cal	Cause (Disaase or Injury that initiated events resulting in death) Last	C. ——	Dua to (or	as a consec	uenca of):						
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death c e attend ed for us			0									
the deay the a	/slc	Part ii. Other significant condition	s contributing to de	eath but not resu	ulting In the u	nderlying caus	e given in Part	1.	23b. Did	tobacco use c	ontribute !	to the cause of death
d by	Ph	CELEBROU ASCU	CAR A	CLIDEN	-	PARKI	USONIS		1□	Yes 2 No	3 Pro	obably 4 Tunknow
w requires that been signed t should be det	Completed by Physician				,	8-1/0-1			040 1910		245 V	Vere autopsy findings
need	etec	DISEASE.								s an autopsy ormed?	e a	valiable prior to completion of cause
has pe 2	mpl											f death?
F # 8		A- 11								Yes 2 MHO	1	□Yas 2□No
Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	/			Other		(Check only			
£ 5 %	1: To	1 ☐ Yas 2 ☑ No 27. Manner of Death	28a. Date	of injury	ER/Outpatier 28b. Tima o		4UN	-		how injury occu	- ' '	ify)
or Attending Fafter death. Director: After In by the funer	tlor	1 Natural 5 Pending 2 Accidant Investige	(Mon	th, Day Year)	Injury	М	Injury at Work? 1 ☐ Yes 2 ☐					
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To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	edical ((Check only 2 ☐ Medical E	Physician: To the xaminer: On the b	esis of examinat	wiedge, deet ion and/or in	occurred et t	he time, dete ar my opinion, de	nd placa, ar ath occurre	nd due to the	ceuse(s) and m	nanner as	steted. to the cause(s)
thin 2	Mec	one) 29b. Signature aparts of certifier	and man	ner stated.		290 1	cansa number			29d. Date sign	ad /Month	Day Year)
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0		ency	1-0		M	O AS	24023	21 60	4005	Mary	10,	1997 CE
10		30. Name and address of person w	no completed caus	e of death (item	23a) (Type,	Print)	11	1 /		Bar -		
01		31. Date filed (Month, Day, Year)	0.30	egistrar's Siana	ture	INAI	MOSP	ITAL	. 07	UNCI	hood	22
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Registrar

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State of Maryland / Department of Health and Mental Hygiene 97 | 4960

				Cert	ificate of	Death		Reg. No.		
Discortati		1. Decedent's Neme (First, Middle, L	ast)				2. Dete of De Month		Year	3. Time of Deeth
Physicia /Medic	_	EARL	LEMON				5	10 1	997	6:45 PM
Examin		4e. Fecility Neme (If not institution, g	ive street and number)			4b. City, Town, or Lo	ocation of Deat	h 4c. County	of Deeth	
		(HOME) 4518 MANO	RVIEW RD			BALTIMOR		N/A		
Funeral Director		5. Social Security Number 6. 248-66-3225 Usuel Residence of Decedent	Sex 7. Age (In y	7 Yrs.	Months Days	The state of the s	8. Dete of Bir (Month, De 7-8-19	th by, Year) 939	9. Birthp	piece (Stete or Foreign S.C.
show	_	10e. Stete 10b. County		City, Town or Loc	ation				1	0d. Inside City Limits
28a-f	Director	MD N/A	B	ALTIMORE						1 Yes 2 No
23a or	rai Dir	4518 MANORVIEW R	D		10f. Zip Code 21229	9		10g. Citizen of V		ntry?
Examiner m	d by Funeral	11. Meritei Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No It Yes, Give Yeer or Detes:	1	es Decedent of Yes, specify Cub	Hispanic Origin? (Spoen, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ck, White,	ean Indien, etc.
natural".	eted	15. Decedent's I (Specify only highest g		16e. Decede	nt's Usuei Occu	pation during most of work	ina	16b. Kind of B	usiness/ind	dustry
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traumatic	-	19e. Informent's Neme/Reletionship	(Type, Print)	19b. Meiling	Address (Stree	t end Number or Run	al Route Numb	er, City or Town,	Stete, Zip	Code)
er tra		JOANN LEMON (W	IFE)	4518	MANORVII	EW RD BALT	O. MD :	21229		
int: If Rem 27 Is iry or other tra		20e. Method of Disposition 1)() Burial 2 Cremetion 3 4 Donetion 5 Other (Special Contents)	Removel from State	Plece of Disposicemetery, creme	etory or other pla	-	Dete /1997	20c. Location -		own, State
Important: It any injury o		21. Signature of Amerat Service Lice	mage /	ES 13	Name end Addr TEP BRO	ess of Fecility THERS FUNE W PLACE BA	RAL HOI	ME P.A.	17	
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							10	Yes 2□No	3 ☐ Prof	bably 4 Unknow
peen sign	Completed by						24e. Wes	en eutopsy ormed?	co	ere eutopsy findings eileble prior to impletion of cause
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director,	ToB	exeminer?	Hospital: 1 ☐ Inpatient 2	P □ ER/Outpatient	3□ DOA Ot	26. Plece of Deet	_	dence 6 □Oth	or /Specif	5/1
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the fune	atio	1 Neturel 5 Pending 2 Accident Investigation	on	njury		Yes 2□No				
Director: d in by the	Certification:	3 Suicide 6 Could not determined	28e. Place of Injury - A building, etc. (Spe	t home, term, stree ecify)	et, fectory, office		28f. Location (City or To	Street end Numb wn, Stete)	er or Rure	el Route Number,
To the Funeral C	edical C	29a. Certifier (Check only one) 1 Certifying P 2 Medicat Exa	hysicien: To the best of my interest of the basis of exemend menner steted.	knowledge, deeth of	occurred et the ti stigation, in my	ime, dete end plece, opinion, deeth occurr	end due to the ed et the time,	cause(s) end me dete and plece,	enner es s' end due to	teted. o the ceuse(s)
ompl		29b. Signeture and title of certifier			29c. Licen	se number		29d. Date signe	d (Month,	Dey, Year)
		* Lauren 9	Toda MA		DS	7700		May 1	2 19	97
_	-	30. Neme and address of person who	completed cause of deeth //	tem 23a) (Type, P	nint)	003 1		· mg 1	- ()	1
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TO BE COMPLETED BY FUNERAL DIR	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or either traumnific event, the medical examiner must be notified at once.
	be filed within 72 hours after death with the State Dept. of Health and Mental Hyperne prior to beneal, cremation, or remo
e funeral director, page 5 should be detached for use as the bunal-transit permit. Page	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the amending perment and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page
death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death continues he symbol within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

30. NAME AND ADDRESS OF

GRIFF

97 14961 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -**CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 5 ANNIE K. LIDE 1997 3:50 P 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 3 30 8. BIRTNPLACE (State or Foreign 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR MONTHS DAYS HOURS 86 213-16-4615 1 M 2 T F 1911 9a. FACILITY NAME (If not institution, give atreet and number, 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH N/A BALTIMORE DIRECTOR 3410 DENNLYN RD (HOME) RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD N/A BALTIMORE 1) X YES 2 - NO 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21216 U.S.A. 2744 DIGGS AVE. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married AFR. AMERICAN 8 3 Nidowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) SOC. SEC. ADMINISTRATION 12 GOVERNMENT 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Malden Surname) **THOMAS** KENDRICK LIZA BENNETT 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT C. HUNT SON-IN-LAW 3410 DENNLYN ROAD, BALTIMORE, MARYLAND 21215 20e METHOD OF DISPOSITION
1 | Burlat | 2 | Cremetton | 3 | Ramo
4 | Donatton | 5 | Other (Specify) _____ 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE ARBUTUS MEM. PARK ARBUTUS MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217 23. PART I. Enter the disease, or complications that caused the death. Do not abook, or heart fellure. List only one cause on each line. Approximate Interval Between **Onaet and Death** IMMEDIATE CAUSE (Final disease or condition___ ETASTATIC KENA 2 YEARS resulting in death) DUE TO (OR AS A CONSEQUENCE OF). Sequentially liet conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other algorificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? t TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATN (Check only o 25. WAS CASE REFERRED TO MEDICAL EXAMINER? OTHER:
4 □ Nursing Home 5 Residence 6 □ Other (Specify) HOSPITAL: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28c. INJURY AT WORK? 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26d. DESCRIBE NOW INJURY OCCURED Netural 2 Accident 5 Pending м 1 YES 2 NO 34 Investigation 28s. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLET 29a. CERTIFIER CENTIFYING PHACE viedge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. AL EX occured at the time, data and place, and due to the cause(a) and manner as stated. 29c, LICENSE NUMBER IGNATURE AND TITLE OF CERTI 29d. DATE SIGNED (Month, Day, Year) MAY 13, 1997 MD

900 CATON AVE.

BALTIMORE

MD. 21259

Mile Toronto Co 122

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 4962 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** MAY MARJORTE M. LEE 11, 1997 4:20 A.M. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FORE ST HILL ar If Undar 24 Hrs. Hours Min. BEL FOREST NURSING HOME If Under 1 Months 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Yrs Director 111-48-9321 JANUARY 18, 1904 SCHUYLERVILLE, N.Y. Usual Rasidance of Decedant 10a, State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☐ No Director HARFORD MARYLAND BEL ATR 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U.S.A. Funeral 811 CHESNEY LANE Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Was Decedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married Specify: WHITE 1 ☐ Yas 2 No Specify: à 3√ Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 HOUSEWIFE HOUSEKEEPING-OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 2 ARTHUR L. MONTGOMERY AMY TODD 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) NANCY L. TATTERSALL (DAUGHTER) 811 CHESNEY LANE BEL AIR, MARYLAND 21014 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata permit. Pages Department of Important: If It any Injury or o Burial 2 Charaction 3 Ramoval from Stata 4 Donation 5 Other (Spacify) METRO CREMATORY, INC. MAY 13,1997 BALTIMORE, MARYLAND 22. Nama and Addrass of Facility E.F. LASSAHN PUNERAL HOME, P.A. 11750 BELATR ROAD KINGVSILLE, MARYLAND 21087-1351 23a. Part1. Entar tha dis asa, or complications that called the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final disaasa or condition rasulting In daath) > 5 year /Medical carliar de Examiner Dua to (or as a consequence of) Examiner bunal-transi Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not rasuiting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed esture heart John 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar?

1 ☐ Yas 2 ≧ No Be 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatlent 3 ☐ DOA Othar:

◆■Nursing Homa 5 □ Rasidanca 6 □ Othar (Specify) 10 28a. Data of Injury (Month, Day Yaar) 27. Mannar of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 2 Accidant 6 Could not ba 3 Suicida 28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a. Certifian 🖾 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. Medical (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Yaar) 1235522 13,1777 30. Nama and addrass of person who complated causa of daath (itam 23a) (Type, Print)

LIS West MACPHA.

State Registrar

Baltimore, Maryland 21215-0020

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Pages 1 and 2 s nent of Health an ant: If hem 27 is r

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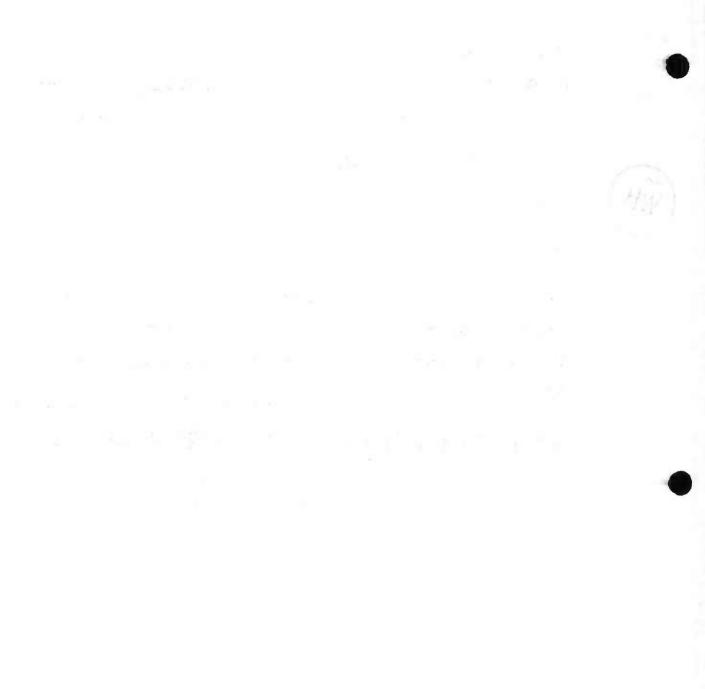
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To the I within 2

funeral

Box 68760.

Division of Vital Records, P.O.



Item 23,27 per MEO Film G747 5-21-97

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

14963

DEON H.MILES State of Maryland / Department of Health and Mental Hygiene Item3 5-15-97 FilmG747 W.H.Per OCME Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath 3. Time of Death Month **Physician** Yaar 11:13 AM DEON MAY 1997 /Medical 4a. Facility Nama (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Mantha Dave Hours Min. (Month, Dey, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1**∭** M 2□ F 0 Yrs. Director NONE December 18,1997 MARYLAND Usual Rasidanca of Decedant filed within 72 hours efter death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits items 23a or 28a-f ahor iner must be notified at 1 Yas 2 No Director MARYLAND PALTIMORE 10e. Straat and Numbar 10g. Citizan of What Country? USA 1832 W. FAYETTE 2122 by Funerai 12. Was Dacedant Evar in U,S Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) Race - Amaricen Indian, Black, Whita, atc. traumatic event, the Medical Examiner 1 Navar Married 2 ☐ Married 1 ☐ Yas 2 No Baltimore, Maryland 21215-0020 ò f Yas, Giva Yaar or Datas: 1 ☐ Yas 2 K No Specify: BLACK Specify: 3 ☐ Widowad 4 ☐ Divorced "natural", Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry al Hygiena. Elamantary/Secondary (0-12) College (1-4or 5+) N/A 0 18. Mothar's Nama (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Haalth and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event Be HARPER MILES LAVERNE EARL 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) LAVERNE HARPER / MOTHER 1832 W. FAYETTE ST., BALTIMORE, MD 21283 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 BBurial 2 Cramation 3 Ramoval from Stata LANS DOWNE, MARYLAND 5-7-97 MIZION CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licenses JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MARYLAND 21217 The tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, for heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immadiata Causa (Finai PNEUMONIA disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be axecuted the burial-transit Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daath) Last end Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? director, paga 2 should be detact 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 □ No 1 Yas 2 No 25. Was casa rafarred to medical 26. Placa of Death (Check only one) axaminar? Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To ty∑ Yas 2 No 1 ☐ Inpatiant 2 X ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28c. injury at Work? 28b. Tima of 28d. Dascribe how injury occurred After 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be dataminad 3 Suicida 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homicida

Division of Vital Records, To the Hospital or Attendii within 24 hours efter death. To the Funeral Director: A In by the pelli completely

> 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) DONALD G. WRIGHT MD

29b. Signatura and titla of certifiar

Donald Ar Wright MD

29a. Cartifiar

Medicai

111 Penn Street, Baltimore, Maryland 21201 31. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. Licansa number

O.C.M.E.

29d. Data signed (Month, Dey, Yeer)

MAY 03, 1997

State

TPELS LYAM

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month JOSEPH MARTIN May 8. 1997 2:00 P.M. /Medicai 4a. Facility Neme (If not institution, give street end numbar) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 3403 Millie Way Manchester Carroll If Under 1 Year If Undar 24 Hrs. 5. Sociel Security Number 7. Age (in yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Days 1⊠M 2□ F Yrs 67 219-22-7388 June 4, 1929 Maryland Usuel Residence of Decedent 10e Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Carrol1 Manchester 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3403 Millie Way 21102 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indien, Bleck, Whita, etc. 1 图 Yas 2 □ No If Yes, Give Year or Dates: 1945–52 1 Never Merried 2 Married Specify: þ 3 ☐ Widowed 4 ₺ Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) 12 years Aircraft Mechanic Commercial Airline 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) James Raymond Onion Marian G. Haskins 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Kathryn A. Bollinger (Daughter) 3403 Millie Way Manchester, MD 20b. Plece of Disposition (Name of cematary, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Lake View Memorial Park 5-12-97 Sykesville, Maryland 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 23a. Pard. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth tmmediete Ceuse (Finet diseese or condition resulting in deeth) Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medical Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the undarlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 thknown Caucer ģ 24b. Wara eutopsy findings evailable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy 1 ☐ Yes 2 ☑ No 1 Yes 2€ No 25. Wes case referred to medicat exeminer? 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner physician and the burial-transit

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 7 Department of Heelth and Mental Hygiene. Important: If Iem 27 Is marked other than "n any Injury or other traumatic avant

or items 23s

the Maryland

72 hours efter death

3altimore, Maryland 21215-0020

Box 68760

P.0.

Division of Vital Records,

9 27. Menner of Deeth Certification:

1 Neturet

2 Accident

4 Homicide

3 Suicida

certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical funeral within 2 To the

Medical

peen

Registrar

29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) and menner as steted. 2 Madical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of certifiar Mus

28a. Dete of Injury (Month, Dey Yeer)

W41614

1 Yes 2 No

28c. Injury et Work?

29d. Date signed (Month, Dev. Yeer)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Court Rd Halle 4,000 OLQ au

31. Dete filed (Month, Day, Year) MAY 1 5 1997

5 Pending Investigation

6 Could not be determined

32. Registrer's Signeture Javidon

28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

on the same of the same

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

14965

						Cert	ilicate of	Deam			Reg. No.		1 1 3 0
Physi /Med		Decedent's Neme (First, Mic ANNE		NCES			POSNER			2. Dete of De MAY 9	, 1 ⁹ 97	Yeer	3. Time of Deeth 7:25 PM
Exam		4a. Fecility Neme (If not instituted GREATER BALT			CENTER			4b. City, To		ocation of Death			IMORE
Funera	al	5. Social Security Number	6. Sex		(In yrs. last birt		If Under 1 Year			8. Dete of Bir (Month, De	th	9. Birth	piece (Stete or Foreig
Directo		120-56-6043	1□ M 💥	F	85	Yrs.	Months Deys	Hours	Min.		9, 1911	Cou	intry) NY
pu ,		Usual Residence of Decedent			40.00 7						J-1-11		
aryla eho	_	10e. State 10b. Cour	•		10c. City, Towr	or Loca	ation						10d. Inside City Limit
M P	Director	MD	N/A				BALTI	MORE					1 Yes 2□N
Việt V	吉	10e. Street and Number		"			10f. Zip Code				10g. Citizen of \		ntry?
23	rai	3041 FALLSTAF		#607D		1		21209				S.A.	
item item	Funeral	11. Merital Status 1 ☐ Never Married 2 ☐ M	Amed	Decedent Every Forces?		13. W	as Decedent of Yes, specify Cut	Hispanic Or Dan, Mexical	igin? (Sp n, Puerto	ecity Yes or No Rican, etc.)	Bied	e - Amen ck, White,	can Indien, , etc.
rs ef	by	31☑ Widowed 4 □ Divorce	if Yes	es 20 No Give or Detes:	,	10	☐Yes 2 XX Yo	Specify:			Specify	WH]	(TE
is 1 and 2 should be filed within 72 hours efter death with the Maryland if Health end Mantel Hygiene. Item 27 is marked other than "naturel", or flems 23a or 28a-f show other traumatic event, its Medical Examiner must be notified at			ent's Education	J. D0100.	16e.	Decede	nt's Usuel Occu	nation			16b. Kind of B	usiness/ir	ndustry
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should end Man s marke	-	19e. Informent's Neme/Relation	nship (Type, Print)				Address (Stree			al Route Numb	er, City or Town,		
1 and 2 Health e em 27 Is		PAUL POSNER	SON		60	054	RITCHIE	HIGH	WAY	BALTIM	ORE, MD	212	225
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Peges tent of int: If it		1 ☐ Burial 2 ☐ Cremetio 4 ☐ Donetlon 5 ☐ Other		om State			R HILLS		5	/13/97	HASTING	S-ON-	-HIDSON. N
고투주론	8	21. Signature of Egheral Service	e Licensee	_	1	_	Neme end Addr				HASTINGS-ON-HUDSON,		
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_		23a. Part1. Enter the disease, shock, or heert failure. L	or complications th	at caused t	he death. Do n	ot enter	00 Reis	terst	cardiac	Road Pi	kesville	e, MI	21208 Approximate
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To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, paga	edicai	29a. Certifier 1 Certify (Check only one) 2 Medic	ing Physician: To ai Examiner: On the	the best of e basis of e nenner stete	xamination end	Vor inve	stigetion, in my	ime, date en oplnion, dee	id plece, ith occurr	end due to the red et the time,	cause(s) end ma dete end plece,	and due t	o the cause(s)
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V		30. Name and address of person Robert M.	(DODE A	ause of dee				55 N.	CHAR	LES ST.	TOWSON	, MD	21204
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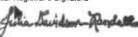
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State of Maryland / Department of Health and Mental Hygiene

14966 Certificate of Death 1. Dacedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Veer **Physician** EDWARD ALBERT PULA May 13. 1997 3:45 PM /Medical 4e. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Baltimore 204 E. Lake Ave. Hours Min. 8. Dete of Birth (Month, Day, Year)

Dec 3, 1928 5. Sociel Security Number If Undar 1 Year 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days 1 X M 2 □ F 220-22-5411 68 Yrs. **Director** Maryland Usual Residence of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits the Maryla 1 No Yes 2 No Baltimore City Directo Maryland N/A 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21212 USA 204 E. Lake Ave. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 | Yas | 2 | No If Yas, Giva Year or Dates: Korean 1 ☐ Nevar Marriad 2 X Married 1 Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Baltimore, Maryland 21215-0 Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry the Me Collage (1-4or 5+) Elementary/Secondery (0-12) Teacher/Administator/Counselor permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: if Item 27 is marked other any injury or other traum-17. Father's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maldan Sumama) Peter Edward Pula Frances Margaret Nowakowski 19a. Informant's Name/Ralationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 204 E. Lake Ave., Baltimore, Maryland 21212 Mrs. Barbara Baldwin Pula (wife) 20b. Place of Disposition (Name of cemetery, crematory or othar placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 N Burial 2 □ Cremation 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 5/16/97 Baltimore, Maryland St. Mary's Ch. Cemetery 21. Signatura of Funeral Service Libense 22. Neme end Address of Fecility Mark Lawren Mitchell-Wiedefeld Home Lawson Martin D. 6500 York Rd., Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Causa (Final disaese or condition rasulting In daath) MYELODYSPLASIA Examiner Dua to (or es a consequança of) Examiner physician and s the burial-trans Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initieted evants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as e consequence of): 950 Por ed by the a Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t fully, HYPONATREMIA 1 Yee 2 No 3 Probably 4 Unknown à 24b. Wara autopsy findings evailable prior to complation of cause of daath? 24a. Was an eutopsy performed? Completed peed certificate 1 Tas 1 ☐ Yas 2 ☐ No l or Attending Physician: after death. Director: After this certifica 25. Was casa rafarred to medical axaminar?
1 ☐ Yas 2 No director. Be 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred Certification: 1 Natural 2 Accidant 5 Panding 1 ☐ Yas 2 ☐ No invastigetion 6 Could not be datarminad To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, streat, factory, offica building, atc. (Spacify) 4 Homicide 1 Cartifying Physician: To the best of my knowladga, daath occurred at tha tima, date and place, and dua to tha causa(s) and mennar as steted.
2 Medical Examinar: On the basis of axemination and/or invastigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha cause(s) and manner stated. 29a. Cartifian Medical (Check only one) 29b. Signetura and titla of certifiar 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cluse of death (Itam 23a) (Type, Print) Donald T. Weglein, M.D. 220 W. Cold Spring Lane, Baltimore, Maryland 21210 31. Data tiled (Month, Day, Year) 32. Registrar's Signatura State Registrar

DHMH 16 Rav 6/95



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 14968 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 10, **Physician** HELEN RESNICK 1997 7:25 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner GINGER COVE HEALTH CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Yeer If Under 24 Hrs.
Months Days Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2√2F Yrs. Director 218-30-7937 Usual Residence of Decadent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ne 23a or 28a-f ahow must be notified at Director ANNE ARUNDEL Yes 2 No ANNAPOLIS the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Herns 23a 4000 RIVER CRESCENT DRIVE 21401 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes Z**ON**o If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No WHITE P Specify: 3℃Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7: and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) s 1 and 2 should be fit Health and Mental H tam 27 Is marked out Be HERSHEL **EPSTEIN** UNKNOWN RACHEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 Is any injury or other trau MALCOLM RESNICK / SON 500 PINEY NARROWS RD #20 CHESTER, MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) MIKRO KODESH BETH ISRAEL 5/13/97 BALTIMORE, MD 21. Signature of Funeral Service Licansee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediate Cause (Final HEPATIC CADCER 1 led disease or condition resulting In death) **Examiner** -transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last and Due to (or as a consequence of): Box 68760 physician Physician/Medical the Due to (or as a consequence of) P.O. | Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 22 No 3 □ Probably 4 □ Unknown been signed t should be det Records, Completed by 24e. Wes en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? Division 1. Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be determined 3 Suicide 28e. Piaca of Injury - Af home, farm, streef, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) end manner steted. 29b. Signature and title of cartifier 29c. License number 29d. Dete signed (Month, Day, Year) 1)3078 person who completed cause of death (Item 23e) (Type, Print) kson fed, 2003 had. PKing + 100, Acropolis, top 20101

State Registrar

a. Spar

State of Maryland / Department of Health and Mental Hygiene

14969

						Cei	rtificate of	Death		R	eg. No.	1	14707
	Physic	an	Decedent's Name (First, Middle, L.	.ast)						2. Date of Deal Month	th Dey	Yeer	3. Time of Death
	Physic /Medi		HERMAN		HERBE	CRT		RON		MAY			4pm
	Examii	ner	4a. Fecility Name (If not institution, g 8416 WINANI		imber)					MORE	4c. County		LTIMORE
	Funerai Director		5. Social Security Number 6. 099-10-8911 Usual Residence of Decedent	Sex 1⊡xM 2□ F	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month, Dey APR. 1	Year) 5,1915	9. Birthi Cou PEN	place (State or Foreign ntry) NSYLVANIA
	e Maryland	ctor	10a. State 10b. County	TIMORE	10c. City, T	Town or Lo		TIMORE	Ξ				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	th with th 23e or 26 ast be no	ai Director	10e. Street end Number 8416 WINANI	DS ROAD			10f. Zip Code	21208	3	1	0g. Citizen of V USA	Vhat Cou	ntry?
020	72 hours effer death with the Maryland natural, or items 23s or 28s-f show diest Examiner must be notified at	by Funeral	11. Maritai Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	Arraged Fo	2 No WWI		Was Decedent of If Yes, specify Cult 1 Yes 2 No	ban, Mexican	gin? (Spe n, Puerto F	ocify Yes or No- Rican, etc.)	14. Rec Blac Specify	k, White,	can Indien, etc. HITE
5-0	72 hours "natural",	eted	15. Decedent's (Specify only highest g		1	6a. Deced	dent's Usual Occu kind of work done	pation	t of workin	na	16b. Kind of Bu	usiness/Ir	dustry
121	withir ane. than	Completed	Elementery/Secondery (0-12)	College (life.	DO NOT use retire SALESMA	ed)	O WOIN	.9	HOME	IMPR	OVEMENT
Maryland 21215-0020		To Be Co	17. Fether's Neme (First, Middle, Let	st)	RO	NES	J. 13351 1	_	er's Name EVA	(First, Middle, I			FELDMAN
	nd 2 sho lith end 27 is me r traum	-	19a. Informant's Name/Reletionship MRS。 MAE RO	(Type, Print) ONES (WI	FE)	19b. Mailir 8 41	ng Address (Stree 6 WINAND	ot and Number OS RD.	er or Rura BALT	I Boute Number	MB 2120	State, Zij	o Code)
Baltimore,	00		20e. Method of Disposition 1		com	etery, crer	osition (Name of metory or other plants		CORP		20c. Location -		
Balt	permit. Pag Department Important: If any injury o		21. Signature of Funerel Servica Lice	ansee	u		Name and Addr SOL LEV	INSON	& BR	ROS., INC		e MIT	21208
ox 68760,	Physician percentificate be executed with control of the province of the principle of the p	v/Medical Examiner	r heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. b. C.	Due to (or as	s a conseq	quence of):	6206	1001	e sulv	J Caly Disease)	Interval Between Onset end Death On will On wi
). Bo	death he etter ed for u	Physician	Part II. Other algnificant conditiona	contributing to d	eath but not resultin	ng in the u	nderlying cause g	iven in Part I	,	23b. Did to	bacco use co	ntribute t	o the cause of death?
, P.O	ires thet the death cer signed by the ettendin d be detached for use	by Phy	MICER D	12067	00	17	-64			1 🗆 Y	● 2 No	.3□ Pro	bably 4 Unknown
Records	aw requisite been 2 shoul	Completed b	CASTRI	C U	/cee	2	9			24e. Wes a perform		av	fere autopsy findings vallable prior to ompletion of cause death?
	0 - 5	Com								1 🗆 Ye	s 2046	1	☐ Yes 2☐ No
/ita	ysician: The	Be	25. Was case referred to medical examiner?						of Death	(Check only on	е)		
Division of Vital	this aldi	ation: To	1 Yes 2 No 27. Manner of Deeth 1 Natúral 5 Pending 2 Accident investigati	28a. Date (Mon		Outpatien b. Time of Injury	28c. Inju		2	ne 5 Aeside 28d. Describe ho			(y)
Divis	Ital or Attuins after de	Certification:	3 ☐ Sulcide 6 ☐ Could not determine	d 286. Place	of Injury - At home ing, etc. (Specify)	, farm, str	eet, factory, office		2	28f. Location (St City or Town		er or Run	al Route Number,
	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Aedical	one) 2 Medical Exa	iminer: On the b	best of my knowled asis of examination ner stated.	dge, deeth and/or inv	vestigetion, In my	opinion, dea	d place, a th occurre	ed at the time, d	ate and placa,	and due t	o the cause(s)
	V T	2	29b. Signature and title of certifier	RV.	0	ИО	29c. Licen	ise number	c -	> 2	9d. Date signer	(Month,	Dey, Year)
	1		30. Name and address of person who	completed caus	sa of death (Item 23	a) (Type,	Print) ()	0	2-	001	211	D 19	271127
	P		31. Date filed (Month, Day, Year)	يلان	1 eug	1	exu	K	No-		nes	1 11	12117)
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State of Maryland / Department of Health and Mental Hygiene Item10e 5-15-97 FilmG747 W.H.Per F/H Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Day **Physician** RESNIKOFF 11, 1997 MAY 9:58 AM /Medical 4a. Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MERIDIAN BRIGHTWOOD NURSING HOME TOWSON BALTIMORE If Under 24 Hrs. 5 Sociel Security Number it Under 1 Year 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthpieca (State or Foreign Country) **Funeral** 11XM 2□ F Days Hours 216-32-8456 Director 87 Usuei Residence of Decedant with the Maryland 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 ☐ Yas 2 ☑ No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4601 SPRINGWATER CT. 21117 #A2 A1# U.S.A. Негла 23а Funeral 12. Wes Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. permit. Pages 1 end 2 should be filed within 72 hours effer a Department of Heelth and Mental Hygiene. Important: If Item 21 is merked other than "natural", or fier any Injury or other traumatic event traumatic event, the Medical Examiner 1 ☐ Navar Marriad 2 X Married 1 Yes WNo It Yes, Give Yeer or Detas: Baltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: WHITE p Specify: 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) OWNER OPERATOR GROCERY STORE 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meidan Surnama) Be **ISADORE** RESNIKOFF REBECCA ZIMMERMAN 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Intorment's Neme/Relationship (Type, Print) DONNA BELSKY / DAUGHTER 4609 TALMAN ROAD BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 5/13/97 BALTIMORE, MD CHIZUK AMUNO ARLINGTON 21. Signetyre Funerel Service Licensea 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. ennon 8900 Reisterstown Road Pikesville, MD 21208 23a. Pert1. Enter tha disaasa, or complications that causad tha death. Do not anter tha moda of dying, such es cardiac or respiretory errast, shock, or heert teilure. List only one ceuse on each line. Approximate intervei Batween Onset end Death **Physician** /Medical Immediete Ceuse (Final disaasa or condition resulting in deeth) Examiner Examiner buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events pue Due to (or es e consequence ot) P.O. Box 68760. physician Physician/Medicai that initieted events resulting in deeth) Last the Dua to (or as e consequenca of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yss 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed peen has page 2 certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifics completely filled in by the funeral director, i Be 25. Wes case reterred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturei 5 Pending investigation 2 Accident 1 Tyes 2 No 6 Could not be determined 3 Suicide 28e. Pieca ot Injury - At home, ferm, street, factory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Steta) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the ceusa(s) end menner stated. 29a. Certifier 29b. Samplide and title of t 29c. Licansa number 29d. Data signed (Month, Day, Yeer) D17118 0 mo completed cause of deeth (Item 23e) (Type, Print) Old Cow-TRd +203 M.D 4000

62, Ragicuar's Signature

DHMH 16 Rev 6/95

State Registrar **Physician** /Medical **Examiner**

The law requires that the death certificate be axecu

been signed by the a should be detached f

page 2

director,

funeral

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Certification: To

Medical

After this certificata

Hospital or Attending Physiclen:

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Box 687

Division of Vital Records,

Physician

/Medical

Examiner

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"natural", or itema 23a or 28a-f ahow

pernit. Pages 1 and 2 should be filed within 72 hours after of Department of Health end Mental Hygiena. Intention 27 Is marked other than "natural", or itea any Injury or other traumatic event, the Medical Execution

Baltimore, Maryland 21215-0020

Director

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Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last Physician/Medicai

Completed by

25. Wes cese referred to medical 1 Yes

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of

Menner of Death 1 Naturei 2 Accident

3 Suicida

4 Homicide

28a. Dete of Injury (Month, Day Year) 5 Pending investigation 6 Could not ba 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

2 XN0

29a. Certifier

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end menner as steted.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signatura and title of certifier

29c, Licansa numbar

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HD 21224

98206

1 ☐ Yes 2 No

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print)

Charlotte 31. Date filed (Mg

JHBHC 4940 Eastern Ave Baltimore

State Registrar

TOP A

		Certificate of Death	Reg. No. 9/ [49]
Physician	Decedent's Neme (First, Middle, Last)		2. Dete of Deeth Month Dey Year 3. Time of Death
/Medical	Mary Elizabeth Schaper		MAY 13 1997 9 mm
Examiner	4e. Fecility Neme (If not Institution, give street end number)	4b. City, Town, or L	ocation of Death 4c. County of Deeth
	Fallston General Hospital	Fallston	Harford
eral ctor	5. Sociel Security Number 6. Sex 7. Age (In yrs. le	st birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min.	8. Date of Birth (Month, Dey, Year) 9. Birthplece (Stete or Foreign Country)
4	212-20-6770 To Mark To		October 3, 1924 Maryland
	10a. Stete 10b. County 10c. City,	Town or Location	10d. Inside City Limits
to	Maryland Harford Fa	allston	1 ☐ Yes 2 🗖 No
Director	10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
	1804 Abelia Road	21047	United States
Funeral	11. Meritel Stetus 12. Wes Decedent Ever in U,S Armed Forces?	 13. Wes Decedent of Hispenic Origin? (Spif Yes, specify Cuben, Mexican, Puerto 	pecify Yes or No- D Rican, etc.) 14. Rece - American indien, Black, White, etc.
	1 Never Merried 2 Merried 1 Yes 2 X No	1 ☐ Yes 2 🕱 No Specify:	Specify: White
d by			
Completed	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usuel Occupetion (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Business/Industry
dwc	Elementery/Secondary (0-12) College (1-4or 5+)	Secretary	Insurance Company
Be C	17. Fether's Neme (First, Middle, Lest)		ne (First, Middle, Meiden Sumeme)
ToB	Charles O. Schobel, Sr.	Myrtle	T. Edwards
	19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rui	ral Route Number, City or Town, Stete, Zip Code)
	Mr. David R. Schaper / Son	1804 Abelia Road Fal	llston, MD 21047
	20e. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stete	nce of Disposition (Neme of metery, cremetory or other place)	Dete 20c. Location - City or Town, Stete
		top Service Corporation	5/16/97 Towson, Maryland
	21. Signeture of Funeral Service Licensee Timothy S. Han	man 22. Name end Address of Fecility	
	Thuy ly S. Han	Leonard J. Ruck, I 5305 Harford Road	Baltimore, MD 21214
	23e. Part Enter the deepen, or complications that caused the death, shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cerdlec	or respiretory errest. Approximete
ו	V		Onset and Deeth
t r	Immediate Cause (Finel disease or condition resulting in deeth)	E CHRONIC RESPIL es e consequence of):	RATORY FAILURE YEARS
	Due to (or	es e consequence of):	
Examiner	b. A CLITE E	XHCERBATION OF C	HRONIC RESPIRATORY Failure
Exa	Sequentially list conditions, if enry, leading to Immediate cause. Enter Underlying Cause (Disease or injury that Initiated events	es e consequence of):	7 month
edical	Cause (Disease or Injury thet Initiated events	es e consequence of): CRSTRUETH	IA with CHRONIC Years
Med	/	OBSTRUCTIVE	E PULMONARY DISEASE YEARS
	d. COR PULL	NATE , NIGHT-SIDE	D HEART FAILURE YEARS
Physician	Pert II. Other significant conditions contributing to death but not result	ing In the underlying ceuse given In Pert i.	23b DISTRIBUTION USE contribute to the cause of death?
Phy	LEFT LOWER LOBE	PAIRIMANIA	(1) Yes 2 No 3 Probably 4 Unknown
	LEFT LOWER LOBE	INCUMINA	
Completed by			24e. Wes en eutopsy performed? 24b. Were eutopsy findings evellable prior to completion of cause.
nple			completion of cause of deeth?
S			1 ☐ Yes 2 ☐ No
Be	25. Wes case referred to medical exeminer?		th (Check only one)
To To			ome 5 Pesidence 6 Other (Specify)
lon	1 Natural 5 Pending (Month, Dey Year)	18b. Time of Injury et Work?	28d. Describe how injury occurred
cat	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home	M 1 Yes 2 No	28f. Location (Street and Number or Rural Route Number,
ertit	4 Homicide determined 256. Place of injury - At nom building, etc. (Specify)	ne, ferm, street, fectory, office	City or Town, State)
edical Certification:	29e. Certifier Certifying Physician: To the best of my knowle	edge, deeth occurred at the time, date and place	and due to the cause(s) and menner as stated
dic	(Check only one) 2 Medical Examiner: On the basis of examinetion one)	n end/or investigation, in my opinion, death occur	red at the time, dete end place, and due to the cause(s)
Me	29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Dey, Year)
	Dalles of C Some	MD- D18'	779 MAY 14,1997
	30. Neme and eddress of person who completed cause of deeth (Item 2		
	ALBERT S.C. SUN.M.D	1800 HARFORD	ROAD, FALLSTON, MD 21047
ite	31. Date filed (Month, Day Year) 32 Registrer's Shatt		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ar	MAY 1 5 199/		

1997 TANK

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Deeth 3. Time of Death **Physician** Harold Foster Stonebraker May 199 0709 /Medical 4e. Facility Name (If not institution, give straat and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Union Memorial Hospital Baltimore City 5. Social Sacurity Number If Undar 24 Hrs. 8. Date of Birth
Hours Min. (Month, Dey, Year) 7. Age (In yrs. last birthday) If Undar 1 Yaar Funeral Birthplece (State or Foreign Country) Deys 1√2 M 2□ F Months 75 181-14-0800 Yrs. Director Dec. 26, 1921 Pennsylvania Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director City Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 21213 U.S.A. 3651 Lyndale 14. Raca - Amarican Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) Amed Forces:

1 X Yas 2 No
If Yes, Give 12/27/39

Yeer or Detes: 09/28/45 1 Never Married 2 Merried 1□ Yes 2□ No by 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Businass/Industry Eiementary/Secondary (0-12) College (1-4or 5+) th. Grade Baltimore Gas&Electric Electrical Foreman 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 Eva Foster Unknown Stonebraker Unknown 19e. informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21213 Madeline M. Stonebraker / Wife 3651 Lyndale Ave. Baltimore, MD 20b. Pleca of Disposition (Name of cametery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete W Buriai 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donetlon 5 ☐ Other (Specify) National Cem. 5/15/97 Balto. Baltimore, MD 21. Signature of Fugleral Servica Licenti 22. Name end Addrass of Fecility John C. Miller, Inc. 23e. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Baltimore, MD 21206 Approximete intervei Between Onsat and Death **Physician** three /Medical Immediate Ceuse (Finel · Respirating wee diseese or condition resulting in deeth) Examiner Due to (or es e consequenca of) fire Examine Chronic Pulminury disease Obstruction 1ews Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting In deeth) Lest Due to (or es a consequence of): Physician/Medical Dua to (or es a consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? X Yes 2 No 3 Probably 4 Unknown umonia, Coronary Arty Dikase Completed by 24e. Wes en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Myocardial Infarction ANO 1 ☐ Yes 2 ☐ No Be. 25. Was case referred to medical axaminer? 26. Piece of Death (Check only one) Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) 1 Yes 2 No 10 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 5 Panding Investigetion Naturei 1 Yes 2 No 2 Accident

Division of Vital Records, P.O. 2 B 2 Pis B Affisi il or Attand after death Director:

28a-f show

ò Items 23a death

traumatic event, the Madical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after of the for the Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or item

or other t

Baltimore, Maryland 21215-0020

3 Suicide 4 Homicide

Certification: in by Medical 29e. Certifier

6 Could not be

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

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28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

May 12

1977

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner stated. 29c. License number 29d. Dete signed (Month, Day, Year)

eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MD

7565 and sman E Weatherworn Way Columbia MD

State Registrar

(Check only one)

29b. Signature end title of cartifier

Sulta Principle Signa

24 hours at Funeral D

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Margaret Loretta 1200 PM 997 4a. Fecility Neme (If not institution, give street end number 4b. City, Town, or Location of Deeth 4c. County of Deeth Saint Agnes Hospital Baltimore N/A if Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1□M XXF Months Deys Yrs 213-72-1932 May 25, 1910 86 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Maryland Baltimore N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4412 Ridge Avenue 21227 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give X 1 ☐ Yes 2 ☑ No Specify: White 3 ₩ Widowed 4 Divorced ear or Dates: 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Thomas Winkler Johanna Engelmann 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jennifer Sroka / Daughter 4412 Ridge Ave. Baltimore, Md. 21227 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, State Warial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Sacred Heart of Jesus 5/14/97 Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name end Address of Fecility David J. Weber Funeral Home 5311 Edmondson Ave. Baltimore, Md. 21229 23e. Pert1. Enter the disease or emplications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory shock, or heart failure. Approximete intervel Between Onset end Deeth immediate Ceuse (Final disease or condition resulting In death) yorardial 05/08-05/11 05/08-05/11 Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings eveileble prior to completion of ceuse of death? 24a. Was an autopsy 2000 1 ☐ Yes 1 ☐ Yes 26. Piece of Death (Check only one)

Physician /Medicai Examiner

Baltimore, Maryland 21215

Pages 1 and 2 should be fill ment of Health and Mental H ant; if flem 27 is marked off

Department of Health Important: If Item 27

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Physician

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Funeral

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physician and the buriel-transit Certification: To

Physician/Medical Completed by Be

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thet the death certificete be executed signed I page 2 s certificate al or Attending Physician: T s after death. Il Director: After this certificat ed in by the funeral director, p To the Funeral D 24 hours Hospital To the Vithin 2

Division of Vital Records, P.O. Box 68760,

State Registrar

Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Pert ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 25. Wes case referred to medical exeminer? Hospitei: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No inpatient in 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deet 28b. Time of 28c, Injury et Work? 28d. Describe how injury occurred 1 A Naturei 2 Accident 5 Pending 1 □ Yes 2 □ No investigetion 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of injury - At home, ferm, streel, factory, office building, etc. (Specify) 4 Homicide 12 Cartifying Physicien: To the best of my knowled ... but occurred et the time, date end pleca, end due to the ceuse(s) and manner as stated.
2 Madical Examiner: On the basis of examination in the property of the ceuse(s) and menner stated. 29a. Certifier (Check only one)

person who completed cause of death (item 23a) (Type, Print)

29c. License number

29d. Dete signed (Month, Day, Yeer)

Paton Ave. Baltimore MD 21229

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31. Dete filed (Month, Dey, Year)

29b. Signeture end 1915 of

MAY 1 5 1997

Mr Savidson

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Iteml 5-19-97 FilmG747 W.H.Per Doctor Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death Mouth **Physician** Maritta 1997 d /Medical 4e. Facility Nema (tf not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALISTOWN BACTIMORE NORTHWEST HOSPITAL CENTER If Under 1 Yeer If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (tn yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** 10M 20 F Months Days 140-92-5488 Yrs. Director Liberia July Usual Rasidence of Decedant nit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland arminent of Health and Mental Hygiene, ortanis if item 27 is marked other than "natural", or items 23e or 28e-f show inluty or other traumatic event, in Medical Earning man be notified at 10e Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 ☐ No Director Ma 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 824 Koad 21208 ber Completed by Funeral 1ar 12. Was Decedent Evar in U,S. Armad Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 11. Maritai Status 1 Nevar Married 2 Married Baltimore. Marvland 21215-0020 1 Yas 2 No 3 □ Widowed 4 □ Divorced Black 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 12th grade Midwit Home years 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be Raye Hemming James Porter 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 824 Koad Moore Daught or 20b. Place of Disposition (Nama by cematary, cramatory or other place) Mikesville, Md 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Surial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) Department o Important: If any injury or Dryid Ridge Cenetery 5 Other (Specify) -24-21. Signatura of Fynaral Sarvice Livens 21215 at 1. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such es cardiec or raspiratory arrast, tick, or haart failura. List only one causa on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Cause (Final ACUTE CARDIAL THROMBOSIS Horns disaasa or condition resulting in daath) Examiner Due to (or as a consequance of): Examiner the bunal-transit Sequantially list conditions, if any, laading to immadiata ceuse. Entar Undarlying Cause (Diseasa or Injury that initiated avents rasulting in daath) Last and Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Records, P.O. Bo The law requires that the death Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Monknown signed by 1 Yes 2 No à 8 24b. Wara autopsy lindings available prior to completion of couse of death? page 2 should Be Completed 24a. Wes an autopsy performed? this certificate 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: director, 25. Was cesa rafarred to medicel 26. Place of Death (Check only ona) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Home 5 ☐ Residence 8 ☐ Othar (Spacify) Certification: To funeral 27. Mannar of Death 28e. Date of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? After 1 1 Matural To the Hospital or Attending within 24 hours after death.

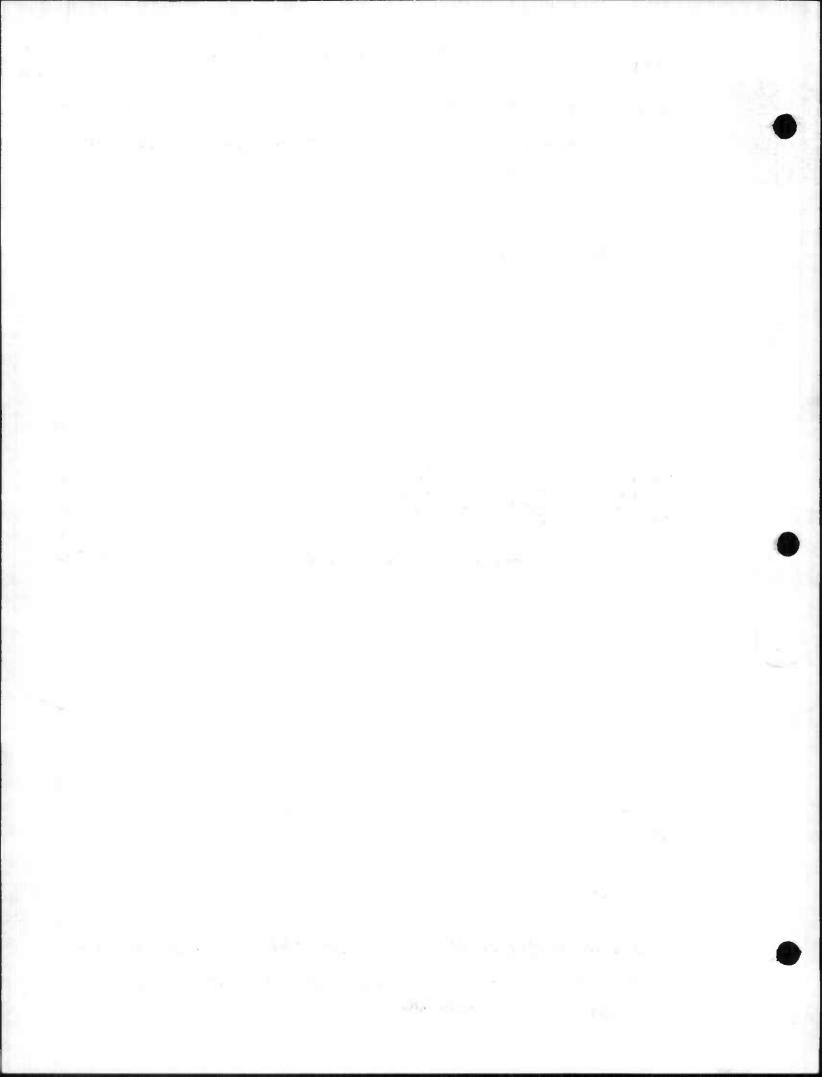
To the Funeral Director: After completely filled in by the fun 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 3 Suicida 6 Could not be 28e. Plece of Injury - At home, farm, straat, factory, office building, atc. (Spacify) Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homiclda Medical 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Dete signed (Month, Day, Year) 30. Nama and eddrass of person who complated cause of death (itam 23a) (Type, Print)

7220 PARK HEIGHTS AVENUE

BALTIMORE, MD 21208

State Registrar DEBORAH PIERCE



State of Maryland / Department of Health and Mental Hygiene 14976 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Death 3. Tima of Death MAnth **Physician** Yaer William B. Washington 1997 OLISOAM 13 /Medicai 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Union Memorial Hospital Baltimore City N/A H Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Sociel Sacurity Number 6 Sex 7. Age (In yrs. lest birthday) If Under 1 Year Birthplace (State or Foraign Country) **Funeral** 12 M 2□ F Months Days Yrs Director 265-10-9286 Jan. 25, 1913 Ga. Usual Rasidance of Decadant death with the Maryland 10a. State 10b. County Show 10c. City, Town or Location 10d. Insida City Limits N/A MD. r than "natural", or items 23s or 28s-f st the Medical Examiner must be notified **Funeral Director** Baltimore 1 No Yas 2 No 10e Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2305 Arunah Avenue 21216 U.S.A. 12. Was Decedant Evar in U,S. Armad Forces? 1 ☐ Yas \$50 No If Yes, Giv6 Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - American Indian, Bleck, Whita, atc. 11 Marital Statue permit. Peges 1 and 2 should be filed within 72 hours efter to Department of Health and Mantal Hygiana. Important: If item 27 is marked other than any injury or other transmits. 1 Never Merriad 25 Marriad 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorcad Completed 16a. Dacedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Maintenance Supervisor Harry M. Stevens 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) Be Bessie McCloud Rev. Reddy Washington 19a. Informant's Name/Relationship (Type, Print) wife 19b. Mailing Addrass (Straat and Number or Rural Route Numbar, City or Town, Stata, Zip Code) Mrs. Ethelean Washington 2305 Arunah Avenue Baltimore, Md. 21216 20b. Placa of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 Burlet 2 Crametion 3 Removal from State 4 Donation 5 Other (Specify) May 17 Baltimore County, MD. Arbutus Memorial Park 21. Signature of Funaral 22. Nama end Addrass of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Balti ase, or complications that cauted the death. Do not enter the mode of dying, such as cardiac or respiretory errest, at List only one cause of mach line. 21216 2501 Gwynns Falls PKWY Baltimore, MD. **Physician** /Medical Immediata Causa (Final diseasa or condition resulting In deeth) ONE WEEK Examiner Dua to (or as a consequence of): Naru rac ONEWCEK and Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Cause (Diseasa or Injury that Initiated events rasulting in death) Last DIRAID Physician/Medical Due to (or as a consequence of): The lew requires that the death the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Atrial Fibrillation Division of Vital Records, þ Be Completed 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an eutopsy performed? Chronic Obstructive Rulmorary Disease HCrpcs ZC

25. Was case rafarred to medical axaminar? 2 No certificata Zoster 1 ☐ Yas 1 Yas 20 No f or Attending Physicien: "after deeth.
Director: After this certifica 28. Place of Daath (Chack only ona) Hospital: 1 ☑ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 2 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) Certification: 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Panding invastigation 1 Tyes 2 □ No 2 Accident in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 - Homicida within 24 hours a To the Funeral C completely filled Hospital edical 12 Certifying Physician: To the best of my knowledga, death occurred at the tima, data and placa, end dua to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, date and place, and dua to the cause(s) and manner stated. 29a. Certifiar (Check only one) To the 29b. Signatura and titla of cartifiar 29c. Licensa number 29d. Data signed (Month, Dey, Year) Moser May M.D. AT2438946 30. Name and address of person who complated cause of death (Itam 23a) (Type, Print)

E. UNIVOSIT

Pkwy, Balt., Md. 21218

Poberis M.D.

State Registrar

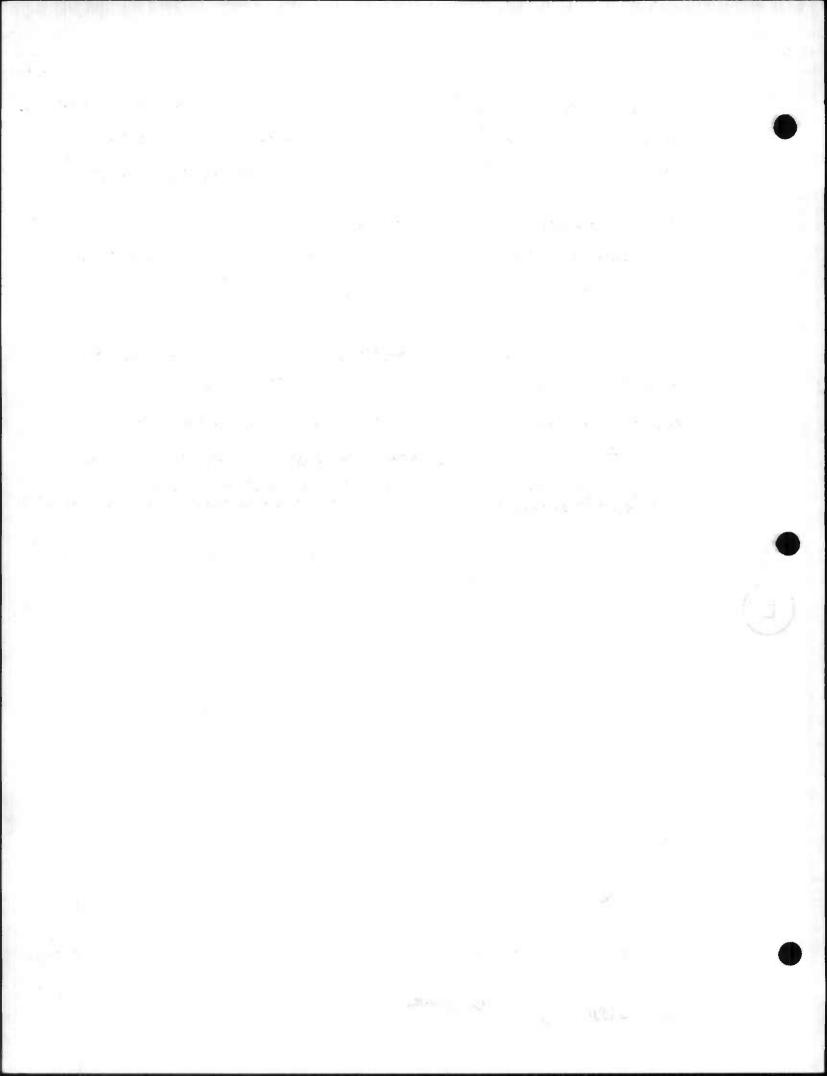
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State of Maryland / Department of Health and Mental Hygiene 4977 Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month 14, 1997 **Physician** Georgie E. Washington May 4:30 a.m. /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore 715 Maiden Choice Lane | H Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | 9. Birthplece (State (Month, Dey, Year) | April 29,1921 | Maryland 5. Sociei Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 1□M 2XF 218-16-1786 Yrs 76 Director Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f show Exaction count be notified at 1 Yas 2 No Director MD Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 715 Maiden Choice Lane 21228 United States permit. Pages 1 and 2 should be filed within 72 hours aftar death v Department of Health and Mental Hygiana. Important: if item 27 is marked other than "naturel; or items 23a eny lojury or other traumatic event, tra Medical Examinet man one. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Maritel Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Merried Merried Baltimore, Maryland 21215-0020 Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) College (1-4or 5+) 12 4 Social Worker Baltimore City 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Arthur Milby Lucille Benjamin 2 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 715 Maiden Choice Lane, Baltimore, MD 21228 George H. Washington/Husband 20b. Plece of Disposition (Nema of cemetary, crematory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriai 2XXCremetion 3 Removel from State 5-15-97 Green Mount Crematory Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nems end Address of Fecility Cafa Stephen D. Lohrmann, P.A. Johnson 8717 Green Pastures Drive, Baltimore, MD 21286 and Employed isease, or complications thet caused the daeth. Do not enter the mode of dylng, such es cerdiec or respiretory errest, book, or heart feilure. List only one ceuse on eech line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) 5 months metastatic long cancer Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseasa or injury that initiated exact.) Due to (or es e consequence of): physician Physician/Medical that initieted events resulting in deeth) Lest Dua to (or as a consequence of) 687 tha The law requires that the death certificant 88 Division of Vital Records, P.O. Box USB signed by the a d be datached f Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings evalleble prior to complation of cause of deeth? 24e. Wes en eutopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 No cartificata Hospital or Attending Physician: 24 hours after death. Funeral Director: Atter this cartifica director. 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ fesidence 6 ☐ Other (Specify)
Injury et 28d. Describe how injury occurred 1 Yes 2N No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27 Mapner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Neturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not ba 3 ☐ Suicida 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 29a. Certifier To the Hosp within 24 hos To the Fune completaly fi Medical (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) May 14, 1997 D40850 eddress of person who completed cause of deeth (Item 23a) (Type, Print) OTTAVIANO MO GOO Carm Are Batimir Md 21229

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year) MAY 1 5 1997

32 Happy Story Story Land



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ITEM# 18 PER F.H. FLM#G747 5/16/97 J.A. Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Deeth Month WILLIAM JACOB WIELAND MAY 11. 1997 7:20 A.M. 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth OAK CREST VILLAGE PARKVILLE BALTIMORE If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) 1 M 2 □ F Deys Hours Yrs. 81 216-03-8696 JULY 27, 1915 BALTIMORE, MARYLAND Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MARYLAND BALTIMORE PARKVILLE 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 8830 WALTHER BOULEVARD APARTMENT 231 21234 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - Amarican Indian, Bleck. Whita, atc. 1 M Yes 2 □ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced WI 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) N/A MILLER MOTOR OFFICE MANAGER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) ANNA RIDDLE FREDERICK WIELAND 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 9666 DUNDAWAN ROAD BALTIMORE, MARYLAND 21236 WILLIAM J. WIELAND, JR. (SON) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 X Burial 2 Cremetion 3 Removel from State 4 □ Donetion 5 □ Other (Specify) PARKWOOD CEMETERY MAY 15, 1997 BALTIMORE, MARYLAND 21. Signature of Funerel Service Licansee 22. Name and Address of Fecility LASSAHN FUNERAL HOME, 23a. Pert1. Enter the diseesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625 Approximate Interval Between Onset end Deeth CONGESTIVE Immediate Cause (Finel BEATT diseese or condition resulting in death) CARDITO MYOPATHI 1 SUHEMIC Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequance of) Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of causa of deeth? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 No

Physician /Medicai **Examiner**

Baltimore, Maryland 21215-

Pages 1 and 2 should be fill ment of Health and Mental H sant: If Item 27 is marked off

Important: If Item 27 is n any injury or other

Physician

/Medical

Examiner

Funeral

Director

28s-f show

Director

Funeral

by

Completed

physician and tha buriel-transit The law requires that the death certificate be executed tha been signed by the should be datached page 2 cartificate

P.O. Box 68760. Records, of Vital Director: Aftar thi Division Attending daath. or A eftar Hospital hours Funeral plately 1 To the Howithin 24 h

Physician/Medicai by Be Completed P 27. Menner of Deeth Certification:

Medicai

29a. Certifiar

1 Neturei

2 Accident

3 ☐ Suicide

4 ☐ Homicide

🔂 cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as steted.

5 Pending Investigation

6 Could not be determined

28e. Date of Injury (Month, Dey Yeer)

28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Straet end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(s) end manner stated. 29b. Signature end title of certifier

recludes my

29c. Licansa number

29d. Data signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

MENENDEZ 7505 OSLER DRIVE #408 TOWSON MD 21204 MARCIO M. MEN 31. Dete filed (Month, Day, Year) M.D.

MAY 1 5 1997



State

(HW)

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1	-	FOR STATE REGISTRAR
_	_	NEGIS INAN

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		CE		ICATE				MEIT INE	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)				H					OF DEATH			3. TIME OF DEATH
	BERNARD		6	JLI	DIDA	RR	CZ	YK	Ma		2	YEAR 97	08:19 PM
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7. DATE	F BIRTH		S. BIRTH	IPLACE (State or Foreign
	214-26-2380	1 😾 M 2 🗆 F	66	YRS.	MONTHS	DAYS	HOURS	MIN.		, Day, Year)	2.1	Countr	
	9a. FACILITY NAME (If not institution, give :		00		9b. CITY,	TOWN C	R LOCAT	ION OF DE		15-19		NTY OF D	ryland
Œ	Church Hospita				Da	144					,	7/-	
6	RESIDENCE OF DECEDENT	11			Ва	111	mor	<u>e</u>				A/N	
DIRECTOR	10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN O	R LOCAT	ION						10d, INSIDE CITY LIMITS?
0	MD	N/A		В	alti	mor	е						1 YES 2 NO
A	10e. STREET AND NUMBER					101	ZIP COD	E			10g. CIT	IZEN OF V	WHAT COUNTRY?
ER	2213 Bank Sti	reet					2	1231			Ţ	JSA	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	IT EVER IN U.S. ARI YES 2 X MAR OR DATES	MED O	1	yes, sp	ecify Cub		n, Puerto F	? (Specify Yes Rican, etc.)	or No-		E — American Indian, k, White, etc. ily: White
	15. DECEDENT'S EDU (Specify only highest grade		16a, DE	CEDENT'S	Work done of	CUPATIO)N	ine	16b.	KIND OF BUS	INESS/IN	DUSTRY	
m.	Elementary/Secondary (0-12)	College (1-4 or 5	life	Do NOT	ise retired.)	runny mo	at OF WORK	ну					
P	6		Ca	rpe	nter					Cons	tru	ctio	n
COMPLET	17. FATNER'S NAME (First, Middle, Last)						18. MOT	THER'S NA	ME (First, A	Middle, Maiden	Sumame)		
BE C	Stanislaus	W	lodarcz	vk			M	arv			Bed	zko	wski
	19a. INFORMANT'S NAME (Type/Print)				G ADDRESS	(Street a	nd Numbe	er or Rural I	Route Numb	ber, City or Town	, State, Zi	p Code)	
10	Jean Schmitt/s	Sister	7	478	Ger	man	Hi	11 R	d.	Balto	. Mo	1 2	1222
	AND ADDRESS OF DISCOURTS AND ADDRESS OF THE PARTY OF THE												own, State
	206. PLACE AND DEPOSITION 19 Burlet 2 Cremetion 3 Cremetion 3 Removed from State 41 Donation 8 Other (Specify) 206. PLACE AND DATE OF DISPOSITION (Name or comment or other place) St. Stanislaus Cemetery 5/16 Baltimore MD.												
	22. NAME AND ADDRESS OF PACEUT David J. Weber FH Baltimore MD. 21231												
	IN IT	W. Ver	/		4	111	1	1	Ba	altimo	OPO	MD.	21231
Z	23. PART I. Enter the diseese, or shock, or heert failure IMMEDIATE CAUSE (Final diseese or condition resulting in death)	List pniy pne ce		5	CF.						and the second		Approximate Interval Between Onest and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	c	DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL	hastory of DID TOBACCO USE CON	poeum	onia					given in	_	24a. WAS AN PERFOR 1 YES 2	MED?	241	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL				ATH (Check								
C	EXAMINER?	HOSPITAL:	☐ ER/Outpatient 3	□ poa	OTHER		no 5 🗆 1	Residence	8 Othe	er (Specify)			
PHYSICIAN:	27. MANNER OF DEATN 1 Natural 5 Pending	28a. DATE O		13 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW I WORK? M 1 YES 2 NO						INJURY OCCURED			
TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide datermined	28a. PLACE building	OF INJURY Al ho J, atc. (Specify)	me, ferm	, atreet, fact	tory, offic	ca .			CATION (Street or Town, State)		er or Rural	Route Number,
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIN 29b. SIGNATURE AND TITLE OF CERTIFI	IER: On the besis of					death occ		time, data		d due to	the cause	(e) and manner as stated. D (Month, Day, Year)
TO BE	97-A. 3	andelo	m	2			1) d	510/	0	> /-	lay	, 12, 97
_	30. NAME AND ADDRESS OF PERSON W	HO/COMPLETED CA	AR'S SIGNATURAL	M 27) (7y)	oe, Print))_	Ch.	mes	1.	Hom	e	7/2	12,97 ospital

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 28 hours after death. Page 6 may be retained by the hospital TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be fined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 2

all permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-16 Rev 1/89

(film)

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State of Maryland / Department of Health and Mental Hygiene

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			Ce	rtificate of	Death	P	eg. No.		. , , , ,
Physician	1. Decedant's Nama (First, Middla, L		RICA	JA		2. Data of Dea Month	th _a_	Yaar Qo 7	3. Tima of Death 4:00 DT
/Medical Examiner	4a. Facility Nama (If not Institution, gi		Clory	, 0,	4b. City, Town, o	r Location of Doath	4c. County	of Death	4:00 pi
LXammer	Hospice of th	ne Chesapeak	ce		Linth			Aru	
Funeral Director	5. Social Sacurity Number 6. 226-34-1031 Usual Rasidance of Decedant	Sax 1 X M 2 □ F 7. Aga (In yr. 64	s. last birthday, Yrs.	If Undar 1 Year Months Days		n. B. Data of Birth Month, Day June 15	Year) 1932	9. Birthpla County North	ca (Stata or Foraign y) Carolina
Maryland and show thed at	10a. Stata 10b. County		City, Town or L Glen I	ocation Burnie				100	d. Insida City Limits 1 ☐ Yas 🌠 No
th with the Mar 23s or 28s-f si set be nonfred al Director	106 Broadview	Blvd., Nor	th	10f. Zip Coda 2106	51	1	Og. Citizan of W	Whet Country USA	y?
within 72 hours effer deeth with the Maryland ene. Than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at mapleted by Funeral Director	11. Marital Status 11. Marriad 2 Marriad 3 Widowed 4 Divorced	12. Was Dacedant Evar In Armed Forcas? 1	U,S. 13.	Was Decedant of If Yas, specify Cub 1 ☐ Yas 2 ▼No		(Specify Yas or No- arto Rican, atc.)		a - Amarican k, Whita, at	
ed within 72 ho ygiene. er than "naturi it, the Wed call Completed	15. Dacedant's E (Specify only highast gi	ducation ada complated)	(Give	dent's Usual Occu	during most of w	rorkina	16b. Kind of Bu	sinass/Indu	stry
mpi	Elementery/Secondary (0-12)	Collaga (1-4or 5+)	lifa.	DO NOT usa ratire	ed)		0		
tal Hygie d other i event, tr	17. Fathar's Nama (First, Middla, Las	t)	Arti	St	18. Mothar's N	ema (First, Middla,	Commer Maidan Sumami		Art
Mental H arked out stic ever	Primitiv	o Africa, S	Sr.			attie	(UNK	1	
pue is m	19a. Informant's Name/Ralationship Primitivo Africa	(Type, Print)	19b. Malli			Rural Routa Number a Springs	r, City or Town,	Stata, Zip C	(ode)
S o E o	20a. Mathod of Disposition 1 □ Burial 2 【X Cramation 3 ☐ 4 □ Donation 5 □ Other (Spec	Ramoval from Stata	cematary, cra	osition (Nama of matory or other pla ematory,			20c. Location -		
Department Important: Pag any Injury o	21. Signatura of Funaral Sanyica Lige	nière (. 6	2. Nama and Addr remation	Society	of Maryl	and, In	nc.	
	23a. Part1. Entar tha disaasa, or cor shock, or haert failura. List only		ath Donot en	tar the mode of dv	rick Ru.	Baltimor	e, MD Z		Approximete
raw requires that the death certificate be associted as been signed by the attending physicien and 2.2 should be detached for use as the buriel-transit inpleted by Physician/Medical Examiner	Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated evants resulting in daath) Last	c	(or as a conse	quenca of):		letas	tase	S.	
attending p		d						1	
les that the death or igned by the attend be detached for us by Physician/	Part II. Other significant conditiona	contributing to death but not ra	sulting in tha t	ındariying causa gi	ivan in Part I.	23b. Did to			the ceuse of death?
ata has been signe page 2 should be c	0.3				. *	24a. Was a	n autopsy med?	com	a autopsy findings labla prior to plation of cause aath?
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frer this certificata uneral director, pec on: To Be Co	25. Wes casa raferred to medical axaminar? 1 Yas 2 No 27. Menner of Death 1 Natural 5 Panding	Hospital: 1 Inpatiant 2 Inpati	ER/Outpatie	nt 3LI DOA	har: 4□ Nursing	Homa 5 Hand 28d. Dascriba h	party of the	Spice or (Specify) ad	of chesap
In the nephral or Attenting Printing 24 hours after death. To the Funeral Director: After toompletaly filled in by the funeral Medical Certification:	2 Accident invastigatio 3 Suicide 6 Could not I 4 Homicide datarmined	OP Diese of laine. At	homa, farm, st		Yas 2 No	28f. Location (S City or Tow		er or Rural F	Routa Number,
in 24 hours he Funera pletaly fills edical (29a. Cartifiar (Check only one) Certifying Pi	nyalclan: To tha best of my kr miner: On tha basis of examin and mannar statad.	owledge, daat etion and/or In	h occurred at tha ti	ima, data and pla opinion, daath oc	ce, and dua to tha c curred at tha tima, o	ausa(s) and me lata and place, e	nner es stat and dua to ti	ted. he ceuse(s)
within To the Comp	29b. Signatura and titla of certifiar	Munc	علما	29c. Lican	3904		9d. Data signed	(Month, De	7ú 1997
3	30. Nama and addrass of person who	complated cause of death (Ita	am 23a) (Type,	Print) Har	off rod	spital she	enter et Bo	ilti	2D 2122
State Registrar	MAY 1 6 1997	gular Davidour M	and a state of			· ·			

Registrar

Transferences.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 01.254 Month Yeer hester 199 14 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth BALTIMORE ST. AGNES HOSPITAL If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) MAY 13, 191 7. Age (In yrs. lest birthday) If Under 1 Year 5. Social Security Number Birthplece (State or Foreign Country) 1⊠M 2□ F Months Deys Yrs. 217-03-6899 85 MARYLAND Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 € No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 207 WESTSHIRE ROAD 21229 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 486 UNION Elementary/Secondary (0-12) College (1-4or 5+) HEATING COMPANY STEAMFITTER 9TH GRADE 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) WILLIAM C. ALLEN NORA H. LORD 19a. tnformant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MARY ALLEN (WIFE) 207 WESTSHIRE ROAD-BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ₺ Burial 2 □ Cremetion 3 □ Removel from State 05/16/97 LORRAINE PARK CEMETERY 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE 21. Signeture of Lune al Service Licensee BARD FUNERAL HOME INC. 4107 WILKENS AVENUE-BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do put enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death Immediate Ceuse (Final COPD disease or condition resulting in death) Due to (or es a consequence of) Duease ro nary Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting In death) Last Due to (or es e consequence of): Prostate Due to (or es e consequence of): Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel examiner? 28. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 1 Nopatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the ceuse(s) end manner stated. (Check only

29c. License numbar

D48098

29d, Dete signed (Month, Dev. Yeer)

Box 68760, ž 2 asn P.O. Records. The law 20 Division of Vital ž Attending Affin

Physician

/Medical

Examiner

Funeral

Director

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Hygiene.

the Medical Examiner must be notified at

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Peges 1 and 2 should be nent of Health and Mental is marked

Department of Health a Important: If Item 27 is any injury or other trac

Physician

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Physician/Medical Examiner

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Certification:

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Saltimore, Maryland 21215-0020

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31. Date filed (Month, Day, Year) 1 6 1997

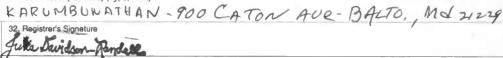
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VIJAY

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

29b. Signeture end title of certifier

DR.



DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death BROADNAX **Physician** WALTER 1220 AM MAY 1997 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BALTIMORE HOSPITAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8 Data of Birth (Month, Day, Year) | 10-11-34 5. Social Sacurify Number 6 Sax 7. Aga (In yrs. last birthday) **Funeral** 1√2 M 2□ F Months 223-44-4995 62 Director Usual Rasidanca of Decedant permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mentel Hyglens. Important: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ¥□ Yas 2□ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1424 N. Milton Avenue 21213 USA 12. Was Decedant Evar In U,S. Armad Forcas? Ña Yas 2 □ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, White, atc. 1 Navar Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highast grada complated) 16h Kind of Business/Industry 7th Grade Collaga (1-4or 5+) Na Diabled NA 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Surnama) P. Bradley Charles Broadnax Geneva 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 2400 Hunter Avenue Bronx, N.Y. 10475 Carolyn Broadnax 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from Stata
Contact Specify Voshell Mem. Gardens 05-19+97 Dundalk, Md. 22. Nama and Addrass of Facility Baltimore, Maryland 21202 21. Signatura di Funeral Service Ligensee WM.C. March FH 1101 E. North Avenue 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. Onset and Death Physician SEPSIS CANDIDA /Medical Immediata Ceuse (Finei disaasa or condition resulting in daath) Examiner Examiner hysician and the burial-transit Sequantially list conditions, if any, laading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated avants resulting in death) Last Dua to (or as a consequance of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical Dua to (or as a consequanca of): Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ASCITES 9 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas certificate 25. Wes casa rafarred to medical Be 28. Place of Deeth (Check only one) 1 Yes 2 Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 2 funeral 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Naturel 5 Pending i or Attendin safter deeth. 1 ☐ Yes 2 ☐ No invastigation 2 Accidant 3 Suicida 6 Could not be datarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) In by 4 Homicide 1 🕊 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifier Medical (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifian 29c. Licansa number 29d. Data signed (Month, Day, Year) MAY

State Registrar 30. Nama and address of person who completed cause of deeth (Itam 23a) (Type, Print) Dr. Chaitan Ravi Randallstown, M.C. NANI MN NIHC. RALTO. MD ZII 335501 Old Court Road 31. Data filed (Month, Day, Year) 32 Finatrar's Signature MAY 16 1997

77777

Mary Topy by VAD

ARTHUR C. BAKER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

4983

Physician /Medical Examiner
Funeral

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7 is marked othe traumetic event, Peges 1 and 2 should be filt ment of Health and Mental Hyant: If itam 27 is marked oth lury or other traumatic event permit. Pege Department of Important: If any injury or

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Box P.O. been signed should be det Records, Division of Vital

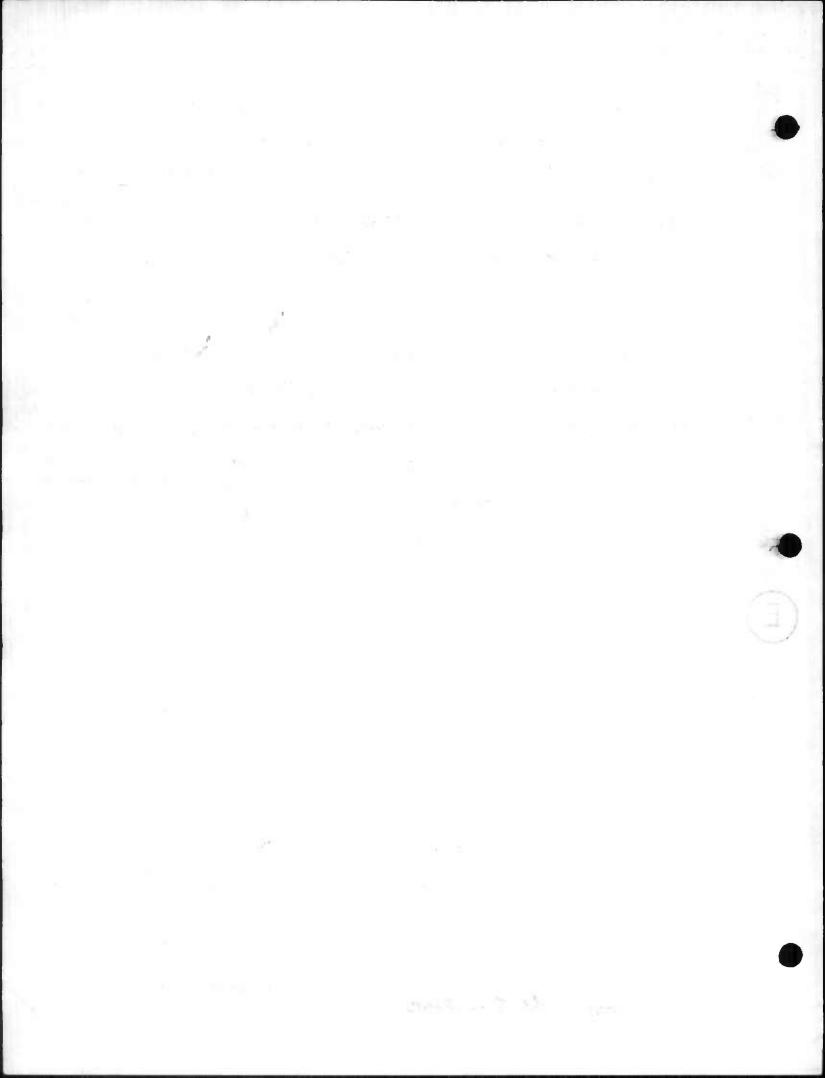
Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certificaleth filled in by the funeral director; To the Hospital
within 24 hours e
To the Funeral C

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Deeth 3. Tima of Death Month 13, MAY 1997 0835 AM BAKER ARTHUR 4e. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY HOSPITAL S.T.U BALTIMORE N/A 7. Aga (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. Hours Min. 5. Sociel Security Number 6. Sax 8. Dete of Birth (Month, Day, Year) Birthplece (Steta or Foraign Country) Days Months 1**√**M 2□ F Yrs 214-92-5829 Usual Rasidence of Decedent 18 MARYLAND MAR 16 1979 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits YYes 2 No Director BALTIMORE CITY MARYLAND N/A 10e, Straat and Number 10f. Zip Coda 10g. Citizen of Whet Country? 1513 POPLAR GROVE STREET U.S.A. Funeral 21216 12. Was Decedant Ever in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc. Was Decedant of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Xivevar Married 2 ☐ Marriad 1 ☐ Yas 2 X X Yo If Yas, Giva Year or Dates: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) STUDENT **EDUCATION** 8th grade 17. Father's Name (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maiden Surnama) ARTHUR BAKER SR, NINA BAKER 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 20b. Placa of Disposition (Nama of cematery, crametory or other place)

20b. Placa of Disposition (Nama of cematery, crametory or other place) Nina Baker/Mother 20a. Mathod of Disposition NBuriai 2 Cremation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) 5-21-97 BALTIMORE, MARYLAND MT. ZION CEMETERY 22. Nama end Address of Fecility WILLIAM C. BROWN COMMUNITY F/H 21: Signature of Funeral Service Licenses 1206 W. NORTH AVENUE 26a. Part1. Enter tha disease, or complications that caused the deeth. Do not antar the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intarval Batween Onsat and Daath Immadiata Causa (Final disaasa or condition resulting In daath) Gunshut wound to head Dua to (or as a consequance of): Examiner Sequentially list conditions, if any, laeding to immadieta causa. Enter Undarlying Ceusa (Disaasa or Injury thet initiated avants resulting in daath) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown by 24b. Ware eutopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy performed? 107 Yes 2 □ No 1DYYas 2D No 25. Was casa raterred to medical axaminar? Be 26. Piaca of Death (Check only ona) Hospital: 1 ☐ Inpatiant XXER/Outpetient 3 ☐ DOA XIXYas 2 No Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) Certification: To 28a. Dete of Injury (Month, Day Year) 28b. Tima of injury 27. Mennar of Death 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yas 2 No 2 Accidant invastigetion 5-13-97 unknown Subject was Shot
281. Location (Street and Number or Aural Routa Number,
City or Town, Steta) 1400 block Popular Grave 6 Could not be determined 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 3 Suicida 4 M Homicide Street Baltimore City, Marylang 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the ceuse(s) and menner as statad.

XIX Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29e. Certifiar Medical 29b. Signatura and titla of cartifier 29c. Licansa number 29d. Data signed (Month, Day, Year) O.C.M.E MAY 14, 1997 30. Nama end eddrass of person who complated cause of deeth (Nem 23e) (Type, Print) Radrntz, MP111 Penn Street, Baltimore, Maryland 21201 Stephyn S.
31. Dete filad (Month, Day, Year)
MAY 17 1997

State Registrar



Completed Be

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Medical

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Certification: To

25. Was cesa raferred to medical axaminar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 TyYes 2 □ No 27. Mannar of Deeth 28b. Time of 5 Panding invastigation 1 Netural

28a. Date of Injury (Month, Day) Tound 5-12-97 © Could not be 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify)

FOUND AT RESIDENCE

28c. Injury at Work? found 0:30

1 ☐ Yas 2 ☐ No

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28d. Dascribe how Injury occurred UNKNOWN

26. Placa of Daath (Check only one)

111 Penn Street, Baltimore, Maryland 21201

29b. Signetura and title of certified

2 Accidant

3 Suicida

29a. Certifier

4 - Homicida

(Check only one)

OCME

29c. Licansa number

29d. Data signed (Month, Day, Year)

1 Yes 2 No

30. Nama and address of parson who completed causa of death (Itam 23a) (Type, Print) Fowler

Bowill 31. Date filad (Month, Dey, Year)

32. Registrar's Signature

MAY 17

Registrar **DHMH 16 Rav 6/95**

State

1₽Yas 2□No

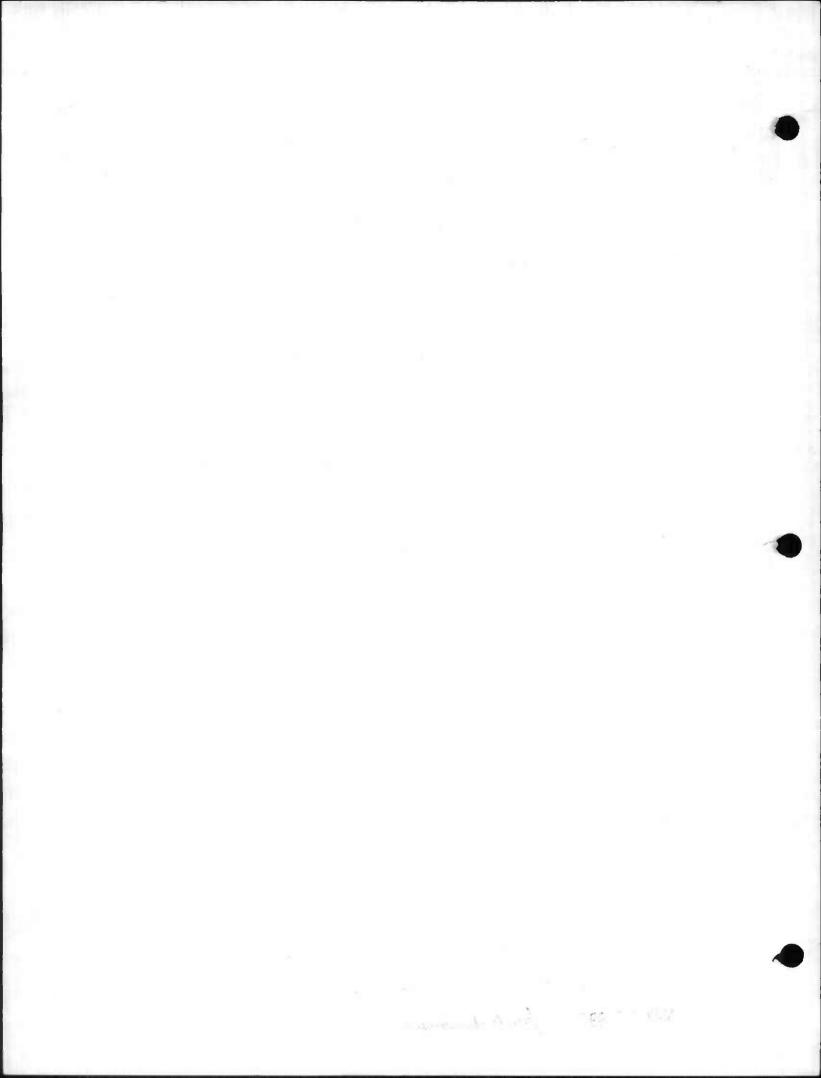
28f. Location (Street and Number of Rural Route Number, City or Town, State) 920 N. BROADWAY

BALTIMORE, MARYLAND

1 Certifying Physician: To the best of my knowledge, deeth occurred et the tima, data and placa, and dua to tha causa(s) and mannar as stated.

2 Madical Examiner: On the basis of examination end/or invastigetion, in my opinion, death occurred at the time, data and piece, and due to the cause(s) end menner stated.

MAY 13, 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Department Important: If any injury o			unerel Service L		0			ss of Fecility Bal				
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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

14986 Certificate of Death 1. Dacedent's Name (First, Middle, Last) 2. Data of Death **Physician** SORDON May /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2080 No 5. Social Sacurity Number Nelson Rd Hartora If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 10€M 2□ F Months Days 84 Yrs. 220 - 09 - 370 | Usuel Residence of Decedent Director Maryland the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is merked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examiner name to notified at Harford 1 ☐ Yes 2 No Director Maryland 10e. Street and Number 10g. Citizen of What Country? 2080 Funeral 12. Was Decedent Evar in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) filed within 72 hours efter Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours eftionent of Health and Mental Hygiene. Int: If Item 27 is merked other than "natural", or I Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specity: White ρ 3 Widowed 4 □ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Dacadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8 yRs. 17. Fathar's Name (First, Middla, Last) BEVAN FRANK 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 end 2:
Department of Health ar
Important: If Item 27 is
any Injury or other trau Beichler HIHAN Head Island, S. C. 29928

Date 2 20c. Location - City or Town, State daughter 100 20b. Place of Disposition (Neme of cametery, cremetory or other place) May 12, 1997 20a. Method of Disposition 1 ☐ Burlal 2 SCremation 3 ☐ Ramoval from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee VANS FUNERAL CHAPEL-BEI AIR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest,

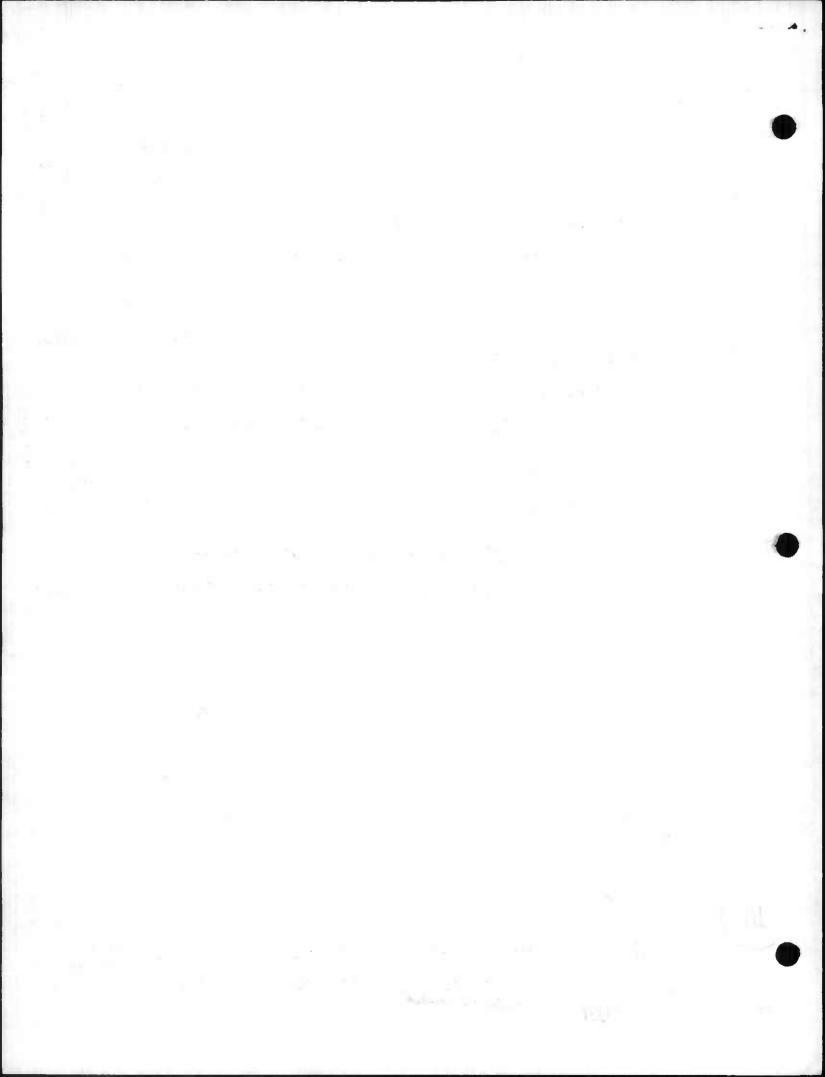
Approximete Physician RESPIRATORY FAILURE

Due to (or as a consequence of):

METASTATIC CARCINOMA, LUNG /Medical immediate Cause (Final disaase or condition resulting in death) Examiner Examine physician and the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 XYes 2 □ No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes an autopsy performed? Completed 2 S.No certificate 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Naturai Lifter death. 1 ☐ Yes 2 ☐ No 2 Accidant 3 Suicide 6 Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 2 4 - Homicide 29a. Certifier Lettifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29b. Signature and title of cartifiar 29c. License number 29d. Date signed (Month, Day, Year) Mely colanto bros 112679 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) Agaton H. Escalant
Date filed (Month, Dey, Year) 31. Date filed (Month, Dey, Year)

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death **Physician** Month 4b. City, Town, or Location of Death Sennett /Medical 4e. Fecility Nama (If not institution, give street end number) 4c. County of Death Examiner Nottingwood Ra 9205 OS COALE Saltemore 6. Sex 1. M 2□ F if Under 1 Year 5. Sociei Security Number 7. Aga (In yrs. last birthday) 9. Birthplece (Steta or Foreign Country) **Funeral** Days Hours -14-6359 Yrs. Director Taryland Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumetic event, the Medical Examiner must be notified at 1 Yas 2 No Maryland Baltimore Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 238 21237 13. Wes Decedent of Hispanic Origin? (Specify Yas or Noff Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Nothngwood Ka Pages 1 and 2 should be filed within 72 hours efter death nent of Health and Mental Hygiene. Int: If Item 27 Is merked other than "natural", or Items 23. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Race - Amarican Indien, Bleck, White, etc. 11. Maritel Stetus 1 ⊠Yes 2 □ No If Yes, Giva Yaar or Dates: WWII 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life., DO NOT use retired) 15. Decedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Automobiles Elementery/Secondary (0-12) College (1-4or 5+) 124RS 17. Fethar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Alfred Bennett 2 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or City or Town, Stete, Zip Code) Depertment of Health ar Important: If item 27 is any injury or other trau Marie Bennett Catherine 20b. Placa of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Memorial Gardens Bel Air, Maryland Chapel of Memories 21. Signeture of Funeral Service Licenses vans 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart feiture. List only one ceuse on each line. Baltimore, Md Approximate Interval Between Onsat and Death **Physician** /Medical Immadiata Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner Sequentielly list conditions, if eny, leeding to Immadiate ceuse. Enler Underlying Ceuse (Diseesa or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of) Pert II. Other significent conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yaa 2 ☐ No Completed by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? page 2 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medical examiner? 26. Piece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27 Marrier of Death Naturel 28e. Dete of Injury (Month, Dey Yeer)

28b. Time of

(Type, Print)

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

5 Pending investigation

6 Could not be determined

eddress of person who completed cause of deg

alle

2 Accident

4 Homicide

29b. Signature end tiple of certifier

rau 31. Dete filed (Month, Day, Year)

3 Suicide

29e. Certifier

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as ateted. 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

1 🗆 Yes

2 No

28d. Describe how injury occurred

Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year) 15

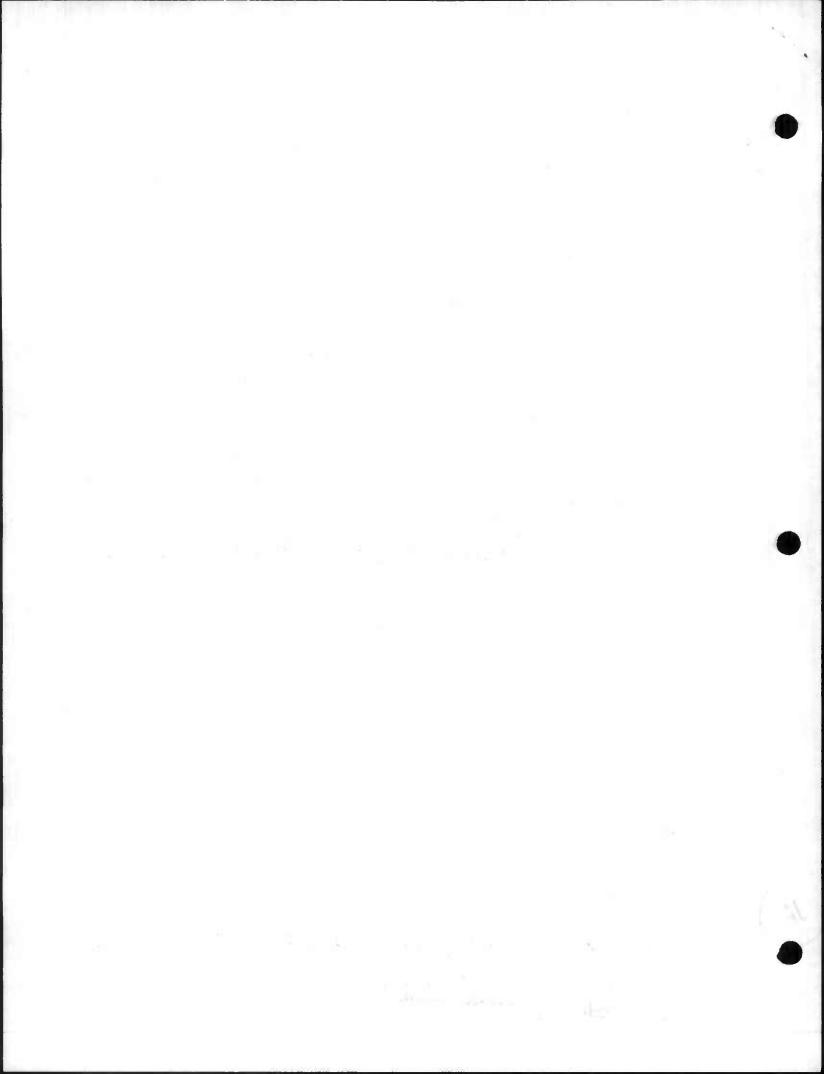
1997

Box 68760. certificate be Division of Vital Records, P.O. signed to d be det 2 After Attending death Director: E or A To the Funeral

Baltimore, Maryland 21215-0020

State Registrar

Medical



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97

14988

						Cel	tificate c	or Death		Reg. No.		
	Physic		Decedent's Nama (First, Middle, L MARY M. BARNES	.ast)					2. Data of Month MAY	200	1997	3. Time of Death 7:00 P.M
	/Medi		4a. Facility Nama (If not Institution, g	ive street end nu	m <i>ber</i>)	-		4b. City. Town	, or Location of De		y of Death	1
	Exami	ner	7970 FOSTER AVE					SEVER	N	ANNE	ARUN	DEL
1	Funeral Director		5. Social Sacurity Number 6. 215-30-2245	Sax 1□ M 2 F	7. Aga (In yrs. 65	last birthday) Yrs.	Months Da		Hrs. 8. Date of (Month,	Birth Day, Yaar) 28,1932	9. Birth	placa (State or Foreign ntry) GINIA
ш			Usual Rasidence of Decedant						ALK.	20,1932	VIII	JINIA
	death with the Maryland ms 23a or 28a-f show ms 15a notified at	tor	10a. State 10b. County MARYLAND ANNE A	RUNDEL		ty, Town or Lo EVERN	cation					10d. Inside City Limits 1 ☐ Yas 2∕☐ No
	the 28s	9	10e, Street and Number				10f. Zip Cod	a		10g. Citizan of	What Cou	ntry?
	23a or	Funeral Director	7970 FOSTER AVE	•			21144			UNITED		
		ner	11. Marital Status	12. Was Deck	edent Ever in U	,S. 13. V	Vas Decedent	of Hispanic Origin	? (Specify Yas or Puarto Rican, etc.)	No- 14. Ra		can Indian,
020	a 9 E	by	1 ☐ Navar Married 2 🖾 Married 3 ☐ Widowad 4 ☐ Divorced		2⊠No va		Yes 2½!		oarto Rican, etc.)	Speci	ack, Whita,	
5-0		eted	15. Decedent's I (Specify only highast g	Education rada complated)		16a. Deced	iant's Usuai Oc kind of work do	cupation na during most of tired)	f working	16b. Kind of E	Businass/in	dustry
21215-0020	Parithic Parithic	Completed	Elementery/Secondary (0-12)	Collega (I-4or 5+)	HOMEM		tired)		OWN HO	OME	
D	Hygin Hygin		17. Father's Name (First, Middle, Las	er)		11011111		19 Mother's	Name /First Mide	dle, Meiden Surna		
lan	should be filed vand Mental Hygie marked other t	To Be	ROBERT LESTER	~/					TRAIL	ore, relevant curria	illa)	
Maryland	ges 1 and 2 should be filed to Health and Mental Hyg If Item 27 is marked other or other traumatic event,		19a. Informant's Name/Raiationship EDWIN L. BARNES)		-			mber, City or Town		Code)
Baltimore,			20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spec		Stata	cemetary, cram	sition (Name of natory or other) JEN MEM	plece)	Data Y 17,'97	20c. Location	100	own, Stata
Balti	parmit. Pa Departmer Important: any Infury once.		21. Signature of Funerei Sarvice bio	ensee		KII	Nama and Ad RKLEY-R	drass of Facility UDDICK F	UNERAL H	OME, P.A		
	_		23a. Part1. Enter tha disease, or con	mplications that o	auend the deat					N BURNIE	, MD	Approximate Interval Between
68760,	Certificate be executed from Indiag physician and Indiag physician and Indiagrams as the burial-transit	ical Examiner	Immediata Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediata causa. Entar Undanying Cause (Disease or Injury that initiated avents	a	Dua to (d	or as a consequence or a consequence or a consequ	uence of):					Onset and Death
99 хо	entifica ling ph e as th	n/Medical	rasulting in deeth) Last	1.4	545.0 (5		34.100 01).					
Bo	attend for us	an		0.								
	e de p	Physicia	Part II. Other significant conditions	contributing to de	eath but not ras	uiting in the un	derlying causa	givan in Part I.	23b. D	ld tobacco use co	ontribute t	o the cause of death?
P.O.	that the death ned by the atter detached for r		Lung ('ance	2 s	prec	nd to	bone	1	₽Yes 2□ No	3 Pro	bably 4 Unknow
of Vital Records,	The lew requires that the deeth ate best been signed by the atterpage 2 should be detached for a	Completed by	0						24a. W	as an autopsy erformed?	av	are autopsy findings railable prior to implation of cause
Rec	ician: The lew certificate has rector, page 2	dwc								□Yes 21XNo		death?
ā			25. Wes casa rafarred to medical	T							11	□ Yas 2□ No
>	Physician: r this certific rral director,	o Be	examinar?	Hospital:		ED/O	□ .□	0.1	Death (Check on			
on of	Attending Physic death. ector: After this by the funeral di	tlon: To	27. Menner of Death 1 Netural 5 Panding 2 Accidant invastigation	28a. Deta (Mont	npatiant 2 of Injury th, Dey Year)	28b. Time of Injury	28c. li	4 □ Nursii njury at Vork? □ Yas 2 □ No	28d. Describ	esidence 8 Ot oe how injury occu		(y)
Division	i or Attendi after death. Director: A d in by the fu	Certification:	3 Suicida 8 Could not detarmined	∠oa. Place	of Injury - At he ng, atc. (Specif		et, factory, offi	Ce		n (Street and Num Town, Stete)	ber or Rur	al Route Number,
	To the Hospital or Attending Phy Within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical C	29a. Cartifier 1 XCertifying P (Check only one) 2 Madical Exa	miner: On the ba	best of my kno- asis of axamina- nar stated.	wiadga, death tion and/or inv	occurred at the astigation, in m	a tima, data end p y opinion, daath o	lace, and dua to the time	ha cause(s) and me, data and place	annar as a , and due t	stated. o the cause(s)
	omp omp	Me	29b. Signature and titia of certifiar				29c. Lice	ense number		29d. Data sign	ed (Month,	Day, Year)
P	-340		· Orani	Lans			D 39	505		MAY 15		
1	15		30. Nama and eddrass of person who									
			YUDHISHTRA MARKA	AN, M.D.	, 1406B	CRAIN	HWY, S	UITE 202	, GLEN E	BURNIE, M	ID 21	1061

DHMH 16 Rev 6/95

Registrar

MAY 1 6 1997

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death 3. Time of Deeth Month Yaer **Physician** Evelyn BAHR 1997 May 13, 1:45 am /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Franklin Square Hospital Center Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. April 20,1916 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foraign Country) 6. Sax 1□ M 219 F Months 81 Yrs. 218-10-9243 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. **Baltimore** Essex 1 ☐ Yes 2 E No Director 10e. Street end Number 10g. Citizan of Whet Country? 10f. Zip Code 21221 USA 1 Eastern Ave. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Rece - Amarican Indian, Black, White, atc. 11 Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give White 1 Yes 2₺ No Specify: by t Yes, Give Yaer or Dates 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 6th Housewife own home 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Bessie Staff Edward Brannen 19a. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Metzger / daughter 1629 Essex Town Circle Baltimore MD. 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Remove from State Holly Hill Cemetery 5/16/97 Baltimore Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 23a. Pert 1. Enter the disease, or complications that caused the death shock, or heer feilure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory errest, Approximete Interval Betw Onset and Deeth Immediate Cause (Finel diseese or condition resulting in deeth) Cor pulmonale 10 Years Due to (or es a consequence of): Examiner Respiratory Failure Sequentielly list conditions, if eny, laeding to immediate causa. Enter Underlying Cause (Disease or injury Due to (or es e consequence of) Chronic Obstructive Pulmonary Disease Physician/Medical thet Initieted events resulting In deeth) Lest Dua to (or es e consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 K No 3 | Probably 4 | Unknown Arteriosclerotic Heart Disease þ 24a. Wes an autopsy performed? 24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? Completed Obesity 2 No 1 ☐ Yes 2 ☐ No Hypothyroidism 25. Wes case referred to medicel exeminer?
1 ☐ Yes 2 ☒ No Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred Certification: 28c. Injury et Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medicai 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, and due to the ceuse(s) end manner es steted. (Check only one) 2 Madical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29b. Signeture end title of certifier 29c. License number 29d. Data signed (Month, Day, Year) May 13, 1997 D17728

Baltimore, Maryland

State Registrar 31. Data filed (Month, Day, Year)

MAY 16 1997

Funeral

Director

7 is marked other than "natural", or itsms 23s or traumatic event, the Modeal Examinar must be r

permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health end Mental Hyglena. Important: If item 27 is merked other than "natural", or iter any injury or other traumetic event, the Medical Example 0059.

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Examiner

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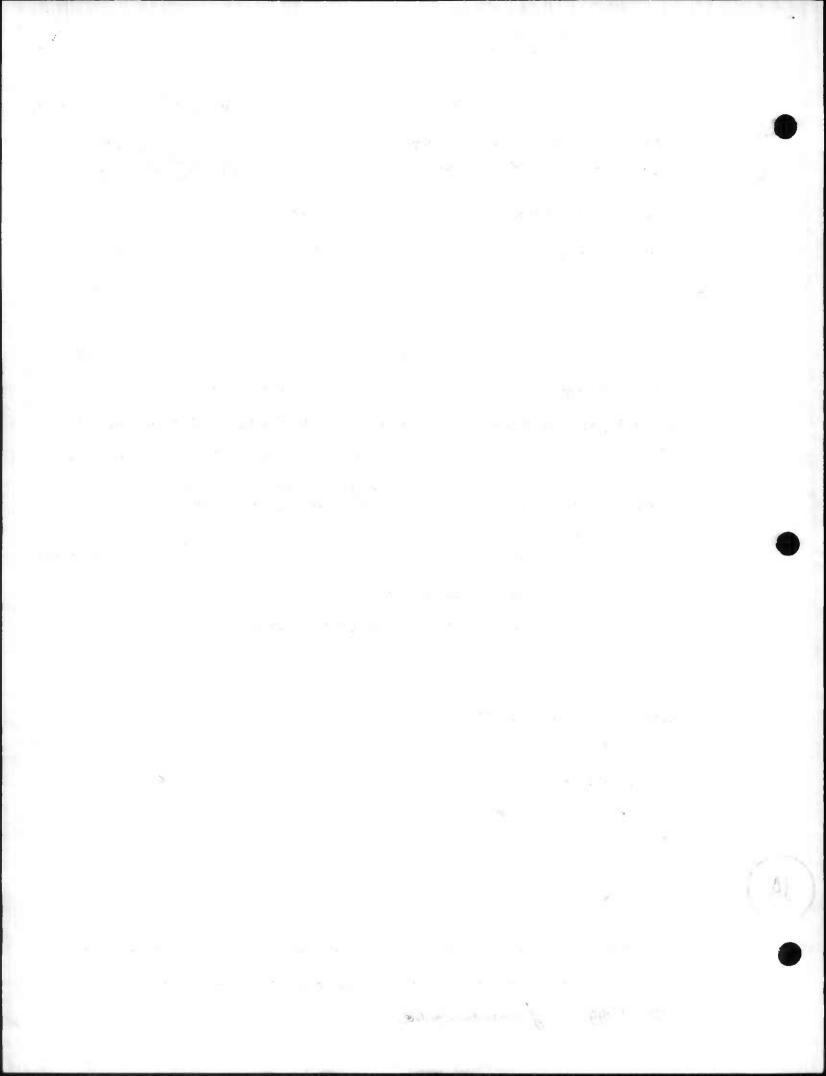
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with the Maryland r 28a-f show

death

Ba Yin Oung M.D. 8022 Belair Road,

30. Name end eddress of person who completed cause of deeth (item 23e) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Daath **Physician** /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** BoHmore If Undar 24 Hrs. 8. Data of Month, 1001 Charles 1timore If Undar 1 8. Data of Birth Month, Day, FEB 25 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Yaar 9. Birthpiaca (Stata or Foraign **Funeral** 10 M 20 F Months Days Yaar) 959 Hours Maryland 214-80-5196 38 Director Yrs. Usual Rasidance of Decadant the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits ms 23a or 28a-f show MD Baltimore Rosedale Director 1 ☐ Yas 2√ No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? filed within 72 hours after death with 1233 Hilldale Road 21237 USA Funeral Itams ; 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. traumatic evant, the Wedical Examiner 1 Navar Married 2 Marriad 21215-0020 ò 1 Yas 2 No Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Spacify only highast grada complated) I Hygiena. Elementery/Sacondery (0-12) Collaga (1-4or 5+) Child Care Provider Day Care other 1 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: If New Z7 is marked other any injury or other was altimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Surnama) Be Francis H. Tippett Carol Charewich 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rurel Routa Number, City or Town, Steta, Zip Coda) Bryan K. Blackburn/husband 1233 Hilldale Rd. Rosedale, MD 21237 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete X Buriai 2 ☐ Cramation 3 ☐ Removal from Stata MD Veteran's Cemetery 5/16/97 4 ☐ Donation 5 ☐ Othar (Spacify) Baltimore, MD 21. Signature of Punaral Saprice Licensee Garrison 2 Roman taddrass of Facility ela. I. MacNabb Funeral Home, P.A. Edward A. Gregorchik 301 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximeta Interval Batween Onsat and Death Physician /Medical Immadiata Causa (Final disaasa or condition rasulting in daath) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificata be axecuted the bunal-tran Sequantially list conditions, if any, leading to immediata ceuse. Enter Underlying Ceusa (Disaasa or injury Dua to (or es e consequance of): Box 68760, attanding physician Physician/Medical that initiated avants rasulting in daeth) Last Dua to (or as a consequence of) for use as Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the causs of death? been signed by 1 ☐ Yss 2 PNo 3 ☐ Probably 4 ☐ Unknown þ Completed 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? certificate has 1 ☐ Yas 2 ☐ No or Attending Physician: Be 25. Wes case refarred to medical 28. Place of Daath (Chack only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 1 ☐ Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 27. Menner of Daath 28b. Time of 28d. Dascribe how Injury occurred Certification: After 1 Naturel 5 Pending Invastigation death. 1 Yas 2 Accident after death Director: None 8 Could not be determined 3 Suicida Place of Injury - At home, ferm, streat, factory, office building, atc. (Specify) 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stata) 4 - Homloida To the Hospital c within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and the of senting 29c. Licansa numbar 29d. Data signad (Month, Day, Yaar) w) 0 30. Nama and address of person with completed ceusa of eath (Item 23e) (Type, Print) Riles North Charles St. Bolto. md 2120 G-61 670 31. Data filad (Month, Dey Year)

State Registrar

MAY 1 6 1997

32. Registrar's Signatura

11 10		1. Decedant's Nama (First, Middla, La		(Certificat	e of D	eath	2. Date of Dec		<i>y</i>	3. Time of Death
Physic /Medi		BERNARD	T	BAL				Month	1D 19	Yaar 97	4:06 AA
Exami		4a. Facility Nama (If not institution, give	va street and number)	-		4b.	. City, Town, or	Location of Death	-	1	
		UNIVERSITY OF	MARYLAND	HOS PITT	72		BALTI	MORE	N	IA	
Funerai Director		5. Social Sacurity Number 6. S		In yrs. last birth	day) If Undar	1 Yaar Days	if Undar 24 Hrs Hours Min.	8. Data of Birt	th y, Yaar) 7, 1949		placa (Stata or Fora
netural, or items 23a or 28a-f show diesi Examiner must be notified at	tor	10a. Stata 10b. County	1	Oc. City, Town	or Location	0.0					10d. Insida City Llm 1 Yas 2 ☐ F
128	Funeral Director	10e. Street and Numbar		Out	10f. Zlp		,		10g. Citizan of	What Cou	intry?
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2 3	ner	11. Marital Status	12. Was Oecedant Eve	ar in U,S.	13. Was Daced	dant of His	panic Origin? (S	Specify Yas or No- to Rican, atc.)	- 14. Rac		ican Indian,
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and A ls me sume		19a. Informant's Name/Ralationship (Type, Print)	19b. h	Mailing Addrass	(Straat an		ural Routa Numbe			ip Code)
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L. EBONY BOVLWARZE

31. Data filed (Month, Day, Year)

32. Regis State Registrar

ARE 22 SOUTH GREENE STREET, BALTIMORE, MARY LAND.
32. Registrar's Signatura

P09727

May 10 1997

DHMH 16 Rev 6/95

30. Nama and address of person who complated cause of deeth (Item 23a) (Type, Print)

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File State in the property of the part of

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Year Lillian Ester Baker May 13, 1997 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Charles Health Care Center N/A Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year)
Oct. 2, 1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Yrs. Director 215-14-5693 79 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 le merked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at Maryland N/A Baltimore XXYes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2700 N. CHarles Street 21218 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturel", or ther any Injury or other traumetic event, the Medical Examines 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify 3 ₩ Widowed 4 Divorced white Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 8 Foreman Hedwin Corporation 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be William E. Wood Bertha Julia Bussey 0 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Hoffman Niece 1017 W. 36th Street Baltimore, Maryland 21211 20a. Method of Disposition 20b. Placa of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 5.16/97 Woodlawn, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Burgee-Henss Funeral Home 3631 Falls Road Baltimore, Maryland 21211 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examine Due to (or as a consequence of) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initieted events resulting In death) Last pug Due to (or es a consequence of): physician s s the burial Box 68760 Physician/Medical Due to (or as a consequence of): grift atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably Woknown signed by P 2 24b. Were autopsy findings avellable prior to completion of cause of death? 24a. Was an autopsy performed? Completed **D809** 2 certificate 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Plece of Death (Check only one) Hospital: Other: Mursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 1 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? Ather 1 Naturel 2 Accident 5 Pending 1 Yes 2 No Investigation actor: 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Phyalcian: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 9 4768 30. Neme and ageress of person who completed cause of death (Item 23a) (Type, Print) Miller Ave., Bulhnoe MD Park Heighte Kaymond 7220

State Registrar 31. Date filed (Month, Dey, Year)

MAY 1.6 1997

32. Hegistraris Signature che Auidson

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State of Maryland / Department of Health and Mental Hygiene

14993 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Daath **Physician** LILLIE Month MAE BROWN 1997 8:00 P.M. May /Medical 4e. Fecllity Nama (If not Institution, give straat and number) 4b. City, Town, or Location of Death Examiner 4c. County of Daath Goodwill Mennonite Home Garrett Grantsville If Under 24 Hrs. 8. Data of Birth Hours Min. Jul 14, 1901 5. Social Security Number 7. Aga (In yrs. last birthday) If Undar 1 Yeer 9. Birthplaca (Stata or Foreign PA **Funeral** 1 M 2 F Months Days 186-50-7323 Yrs. Director Usuai Residance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 23a or 28a-f show event, the Medical Examiner must be notified at PA Somerset RD 1 Meyersdale Director 1 ☐ Yas 2√ No 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 15552 USA Funeral "natural", or items 12. Was Dacedent Evar in U.S. 11. Maritai Status Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Race - American Indian, Black, Whita, atc. permit. Peges 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Department of Health are marked other than "natural", or ite any injury or other traumatic event, it a feating Examine 1 Nevar Marriad 2 Married ☐ Yas 2 f Yes, Giva 2 🛛 No Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: by ₩Widowad 4 Divorced White Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Housewife Home 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Surnama) Be Harvey J. Engle Minnie Enos P 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Code) Dorothy Hare RD 1 Meyersdale, Pennsylvania 15552 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Removal from Stata 4 Donation 5 Othar (Specify) Paul Cemetery 5/12/97RD 1 Meyersdale PA 22. Nama and Address of Facility 21. Signatura of Funarai Sarvice Licensaa M. Ray Leckemby Funeral Home complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, only one cause on each line. 203 North St. Meyersdale, PA. 15552 23a. Part1. Entar tha diseasa shock, or heart failure. I Approximeta Interval Between Onset and Death Physician /Medical Immediata Causa (Final disaasa or condition resulting in daath) ONGESTIVE mond Examiner Due to (or as e consequance of) Physician/Medical Examiner 1,-10 years The law requires that the death certificate be executed Sequantielly ilst conditions, if any, leading to immediata causa. Enter Undarlying Causa (Disaasa or Injury that initiated evants rasulting in daeth) Last buriel-tran e consequance of) P.O. Box 68760, physician s the buriel Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ģ 24b. Were autopsy findings evelleble prior to complation of causa of death? Completed 24a. Was an autopsy 2 No 1 Tes 1 ☐ Yas 2 ☐ No of Vital Physician: Be 25. Was casa rafarred to medical examinar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 2 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA this Certification: 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred ision Attac 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 4 ☐ Homicida 1 Destitying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the causa(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a. Certifiar Medical 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Yaar) 30. Name and in dress of person who con plets ed cause of death (Itam 23a) (Type, Print) 911185 13817201 31. Date filed (Month, Day, Year) State Registrar

DHMH 16 Rev 6/95

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	1 - STATE OF MARYLA		MENT OF HEALTH AI			
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF DEATH
	ROSABELLE COUCH			MAY 12	1997	9:00 P M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In	yrs. last birthday)	F UNDER 1 YEAR IF UNDER 24 I			HPLACE (State or Foreign
	241-36-7542 10 × 35 80	YRS.	ONTHS DAYS HOURS M	(Month, Day, Year) 04-12-	Count	NC
	9a. FACILITY NAME (If not institution, give atreet and number)		Db. CITY, TOWN OR LOCATION		9c. COUNTY OF I	
DIRECTOR	Harford Gardens Nursing		Baltimore	OF DEATH	NA	DEATH
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	I so CITY	TOWN OR LOCATION			
E						10d. INSIDE CITY LIMITS?
	MD NA	ងខ	ltimore			1XXYES 2 □ NO
HA	4700 Harford Road		10f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL			21214			SA
5	11. MARITAL STATUS 1 Never Merried 2 X Married FORCES? 1 YES	U.S. ARMED 2 NO		ISPANIC ORIGIN? (Specify Verlexican, Puerto Rican, etc.)	or No- 14. RAC	E — American Indian, k, White, atc.
B	3 Widowed 4 Divorced IF YES, GIVE WAR OR DAT	res XX	1 TES 2X NO		Spec	
	15. DECEDENT'S EDUCATION				1	22001
COMPLETED	(Specify only highest grade completed)	16a. DECEDENT'S U: (Give kind of wo life. Do NOT use	k done during most of working	16b. KIND OF BU	SINESS/INDUSTRY	- Charles 1
2	Elementary/Secondary (0-12) College (1-4 or 5+)					
\rightarrow	1.2th Grade NA	Seamst			erite C	ompany
	William Roberts			S NAME (First, Middle, Maiden		
H	19a, INFORMANT'S NAME (Type/Print)		Lau	_		
2			DDRESS (Street and Number or I			21239
	Mary Urquhart		Sheridan A		ore, Ma	ryland
	TX_XBuriel 2 Cremation 3 Removal from State cemet	tery, cremetory or othe	DISPOSITION (Name of r place)		CATION — City or To	
	4 Donation 5 Other (Specify)	ing Men	. Pk. Cem.	05-17-97		
	21. SHOWAT CHE OF PUREME SERVICE LICENSEE)	22. NAME AND ADDRESS (DF FACILITY Baltin	more, M	aryland
	Throtte K. S	Ames	WM.C. Mar	ch FH 1101	E. Nor	th Avenue
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury		RCINOMA			Interval Between Onset and Death
	PART II Other classificant and distance A to all all and an articles are a second as a sec					
NA I	PART II. Other algnificent conditions contributing to deeth but	t not reaulting in	the underlying ceuse give	n in Part I. 24s. WAS AN PERFOR		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
PHYSICIAN: MEDIC		<u>.</u>		1 _ YES 2	DING	OF DEATH?
ž						1 TYES 2 NO
Ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF			TAIN 🔲		
ᅙ	EXAMINER? HOSPITAL:	S. PLACE OF DEATH	(Check only one)			
ΥS	1 YES 2 NATO 1 Input lent 2 ER/Output	lent 3 DOA 4	Nursing Home 5 ☐ Reside	nce 8 Other (Specify)		
표	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year)	28b. TIME (OF 28c, INJURY AT WORK?	28d. DESCRIBE HOW I	NJURY OCCURED	
à l	2 Accident Investigation		M 1 YES 2 NO	>		
COMPLETED	3 Suicide 6 Could not be 4 Homicide determined 28e. PLACE OF INJURY – building, etc. (Specify	A1 home, farm, stre	et, factory, office	281. LOCATION (Street a City or Town, State)	and Number or Rurel F	Route Number,
9	29e. CERTIFIER		new his	Versia estado esta	- 17 7	
₹ I	(Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowled one) 2 MEDICAL SYMMINED: On the basic of applications of the basic of applications of the basic of the ba	dge, desth occurred	at the time, date and place, end	I due to the cause(s) and mar	nner as stated.	
႘၂	one) 2 MEDICAL EXAMINER: On the basic of examination of	moor investigation,	in my opinion, death occured a	t the time, data and place, an	d due to the cause(s	and manner as stated.
10 BE	Deboral of Science		29c. LICENSE	93/	May	(Month, Day, Year) 14, 1997
	M. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEAT					
	DEBORAH PIERCE 7220 PARK HE		ENUE BALTIMO	ORE, MD 2120	08	
	31. DATE FILED (Month, Dey, Year) MAY 1 6 1997	URE				
	MAY 16 1997 guha Davidson	N-North				



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State of Maryland / Department of Health and Mental Hygiene

14995

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Dhysisi		Decedent's Neme (First, Mid.	dle, Last)								2. Dete of D Month	eeth Dey		Year	3. Time of Death
Physici /Medic			argaret										199		3:30am
Examir		4e. Fecility Neme (If not instituti	on, give street en	nd num <i>bei</i>	7)				4b. City, T	own, or L	ocation of Dee	th 4c. Co	ounty o	f Deeth	
		1704 Selma	Avenue	2					Ha1e	thor	-			mor	е
Funeral Director		5. Social Security Number	6. Sex		nge (in yrs. las 79	st birthday) Yrs.	If Under Months	1 Year Deys		Min.	8. Dete of B (Month, D Sept.	irth	917	9. Birthi Cou	plece (Stete or Foreign http:// ryland
pu *		Usuel Residence of Decedent 10a. Stete 10b. Count	N.		10- City	Tour out o	antina								
death with the Maryland ms 23a or 28a-f show r mast be notified at	ctor	Maryland Balt	•			Town or Lo etho									1 ☐ Yes 2 2 No
or 28	Jre.	10e. Street and Number					10f. Zip					10g. Citize			,
th w	a l	1704 Selma A	Avenue				2	122	7			Unit	ed	St	ates
or its	by Funeral Directo	11. Maritel Status 1 Never Married 2 Me 3 Widowed 4 Divorce	orried 1 🛄	Decedented Forces Yes 2 os, Give r or Detes:		1	Wes Deced f Yes, spec 1 ☐ Yes				ecify Yes or N Rican, etc.)		Bleck	, White,	etc. ite
2 hot		15. Decede	nt's Education			16e. Deced	dent's Usue	ol Occup	petion			16b. Kind	of Bus	iness/In	dustry
hin 7 In "n Med	Completed	(Specify only high Elementery/Secondary (0-12)	1	eted) ege (1-4or	.5.)	16e. Deced (Give life. L	kind of wo DO NOT us	rk done e retire	during mo d)	st of work	ing				,
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othe	Bec	17. Fether's Name (First, Middle	, Last)						18. Moth	er's Nam	e (First, Middle	e, Meiden Su	<i>im</i> eme)	
fenta fenta ked ked	ToB	Francis Edga	ar Cadd	len					Mar	y Th	neresa	Swid	ck		
shour Ind N		19e. Informent's Name/Relation	ship (Type, Print	t)		19b. Mailin	ng Address	(Street	and Numl	er or Rur	el Route Numi	ber, City or T	own, S	State, Zij	Code)
nd 2 alth a 27 lg		Paul J. Casho	our, so	on		701	MacPl	hai	1 Co	urt	N Bel	Air,	Ma	ry1	and 2101
s 1 a f Hear ftern othe		20e. Method of Disposition				ca of Dispo	sition (Nen	ne of			Dete	20c. Loca	tion - C	City or To	own, Stete
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permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exe once.		21. Sipringro of Timeral Service				Ar	Name en	d Addre	ss of Fecil Fune	ra1	Home,	Inc		Arb	utus 227
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DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene 4996 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month AGNES 10:00 AM CARLOS MAY 97 07 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL SAMARITAN BALTIMORE 9. Birthpiece (State or Foreign 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 1 M 284 F Months Deys Hours Min 96 Yrs. MARYLAND 212 26 0660 MARCH 1 1901 Usuel Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No BALTIMORE MARYLAM Cockeysvills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code (2) O 62 21230 U.S.A. 16 FLANDER 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 250 No It Yes, Give Yeer or Dates: 14. Rece - American indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2 ☐ Married 1 Yes 28 No Specify: Specify: 3 Widowed 4 Divorced STIHEN Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Federal Bank of Elementary/Secondary (0-12) College (1-4or 5+) Clerk BYRS Richmond 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) JOHN UNKNOWN 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Keusville 1d 21030 (0 20a. Method of Disposition

1 Surial 2 Cremation 3 Removel from State 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 9 May 199 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vall HANFORD URDE FUNCALL Rd 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NTRACRANIAL DAYS Due to (or es e consequence ot): HYPERTENSION YEARS Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequenca of): thet Initiated events resulting in death) Last Due to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown

Physician /Medical Examiner

and

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the signed by

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P.O. Box 68760,

Records,

Division of Vital

The law certificate hes

certificate be

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

2

Funeral

Director

show

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

"natural"

end Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health end Mental Hy important: If item 27 is marked other any injury or other traumatic event

death with the Marylend

filed within 72 hours efter

Baltimore, Maryland 21215-0020

Examiner buriel-trensit ending physician are use as the buriel-Physician/Medical A 90 page 2 should Completed Be 2

PNEUMONIA

24a. Was en eutopsy performed?

24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 ☐ No

25. Was case reterred to medical 1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined Dete of Injury (Month, Dey Year)

28b. Time ot

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Placa of Injury - At home, tarm, street, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 🗆 No

28d. Describe how Injury occurred 28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

BALTIMORE

29a. Certifier (Check only one)

1 Natural

2 Accident

3 ☐ Suicide

4 T Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the cause(s) and manner as steled.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature end title of cartities

P10581

29d. Date signed (Month, Day, Year) 74 May

MD

21239

lyman Kotelsh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

AYMAN KOTEISH 31. Date filed (Month, Dey, Year) MAY 16 1997

LOCH RAVEN BLVD 5601 July Raysungs Signature Aundal

State Registrar

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nysicia		1. Decedent's Name (First, Middle, L.	7 G-747 eol			0	of Death	2. Date of De	Reg. No.	g Th	ne of Death
Medic	al	Harry 4a. Fecility Name (If not institution, g		harl		Co	dy John Town	April or Location of Deat	23 /	997 2	300
kamin	er	Joseph Richie H		5617			Baltin			imore Cit	- 77
neral		Social Security Number 6.	Sex	7. Age (In yrs.		If Under 1 Y	ear If Under 24 H		rth	9. Birthplace (Si	
ector		251-64-6253 Usuai Residence of Decedent	122 (VI 201	40 - 58	Yrs.					S. Caro	
ad at	or	10a. State 10b. County unknown unkn	own		y, Town or Lo nknown	ocation					de City Limi
moth	rect	10e. Street and Number				10f. Zip Co	da		10g. Citizen of N	What Country?	
25	0	unknown				u	nknown		U.S.A.		
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month J. Ciotola lona May 13, 1997 9:00 P.M. /Medical 4a. Facility Name (If not Institution, give straet and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** N/A 2743 Pelham Avenue Baltimore If Under 24 Hrs.
Hours Min.

8. Defe of Birth
(Month, Dey, Year)
Sept. 27,1918
Mary Land 5. Sociel Security Number If Undar 1 Yaar 7. Age (In yrs. last birthdey) 9. Birthplaca (State or Foreign **Funeral** 1 □ M 2 X F Deys Yrs. Director 220-05-9247 78 Usuel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 2743 Pelham Avenue 21213 238 U. S. A. 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marifal Stefus Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Bleck, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorcad White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Businass/Industry (Specify only highest grede completed) Elemantary/Secondery (0-12) College (1-4or 5+) Com 21 Union 12th Grade Secretary altimore, Maryland 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Meiden Sumama) th and Mental # Be 8 Luige Caperna Adele Giralico Pages 1 and 2 should 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Health 11 S. Collington Ave., Baltimore, Maryland 21231 Frank Ciotola (Son) If Item 27 20a. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cramation 3 ☐ Removel from Stafe important: Il any injury o once. 4 ☐ Donafion 5 ☐ Other (Specify) 5/16/97 Green Mount Crematory Baltimore. Maryland 21. Signature of Funeral Sarvice Licansee 22. Name end Address of Fecility Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213

23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Finel As trucytomA disease or condition resulting in deeth) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thef initiated events resulting In deeth) Lesf Due to (or es e consequenca of): P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): attending for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yas 2 No 3 Probably 4 Unknown Records, Completed by cate has been signated bage 2 should b 24b. Were autopsy findings available prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 20 No 1 ☐ Yas 2 ☐ NO Division of Vital Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Homa 5 Hasidance 6 Other (Specify) 1 Yes No 10 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Tima of 28d. Describe how Injury occurred After Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: A 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical 29e. Certifier 2 Madical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end place, end dua to the ceuse(s) end manner sfeted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) eted cause of death (Item 23e) (Type, Print) 30. Name end address of person with State Registrar

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State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtificate	of i	Death		Re	eg. No.	21	1 :4	232
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Exami		4e. Fecility Neme (If not institution	n, give street end i	num <i>ber)</i>			4	b. City, Town,		-	4c. County	N. A.		
		Franklin Squar	e Hospit	al Cente	r		1	Roseda1	Le		Balti	more		
Funeral		5. Sociel Security Number	6. Sex	7. Age (In yrs.		If Under 1		If Under 24	Hrs. 8. De	te of Birth				
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deeth with the Meryland rms 23a or 28a-f show r must be notified at	al Director	10e. Street end Number 5522 Daybreak	Terrace			10f. Zip C	ode .206	5			Og. Citizen of 1 United:			
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"netural",		15. Deceder	t's Education		16e. Dece	dant's Usuai (Occup	etion			16b. Kind of B			
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Health and Menter 27 is marke		19e. Informent's Neme/Rejetions	hip (Type, Print)		19b. Maili	ng Address (Street	end Number o	r Rurel Rout	e Number,	City or Town,	Stete, Zip	Code)	
Department of Health en Important: if Nem 27 is any injury or other trainings.		Mrs. Gloria E.	Singleto	n / Daughte	5	522 Day	vbr	eak Ter	rrace	Ba1	timore	. Md	. 21	206
F Herr fem tem othe		20e. Method of Disposition		20b. F	Piece of Dispo	osition (Neme	of		Det		20c. Location	-		
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Deperiment in portion in procession in proce		21. Signeture of Funerer Service	Cicensee Mark	T. Zavo	yrıa 2	2. Neme end . Leonal	rd	J. Ruck	k. Inc					
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		23a. Part1. Enter the disease, a shock, or heert failure. List	complications the	t caused the deet	h. Do not en								Approxir Intervel I	nete Between
Physician													Onsat er	nd Death
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page	00									1□ Ye	s 2 No	10	☐Yes 2	2□ No
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五百		27. Manner of Death	28e. Dat	a of Injury	28b. Time o	f 28c	Injun	et et	_		w Injury occur			
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aftar death Olrector: A In by tha f	110	3 Suicide 6 Could determ	ined 286. Pla	ce of Injury - At he	ome, farm, sti	reet, fectory, o	office				reet end Numb	ber or Rura	al Route N	lum ber,
	Certification:	4 Homicide	bui	lding, etc. (Spacif	y)				Ci	ty or Town	, State)			
24 hours a Funeral C letely filled		29a. Certifiar 1D Certifyin	g Physician: To the	ne best of my kno	wledge deet	h occurred et	the tim	a data and n	iace and du	e to the ce	use(s) and ma	anner es s	teted	
offin 24 hours affi form Funeral Dir completely filled in	edicai	(Check only 2 Medical one)	Examiner: On tha	basis of exemine	tion end/or in	vastigation, In	my of	olnion, death o	occurred et ti	ha tima, da	ite end pleca,	end due to	the ceus	e(s)
dwo	Ž	29b. Signeture end title of certifie		or outed.		29c I	icens	number		20	9d. Date signe	d (Month	Dav Yee	r)
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V		Stuart Willes	M.D. 9	000 Fran	klin S	quare	Dri	ve, B	altimo	ore,	Maryla:	nd 2	21237	

State Registrar

31. Dete filed (Month, Dey, Year)

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State of Maryland / Department of Health and Mental Hygiene

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MAY 11,1997

Physician
/Medical
Examiner

Funeral Director

with the Marylend "natural", or items 23s or 28s-f show adical Exercipe Dust be notified at

permit. Peges 1 and 2 should be filed within 72 hours efter death v Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s sny injury or other traumatic event, the Medical Example I was Baltimore, Maryland 21215-0020

Physician tmmediete Ceuse (Final diseesa or condition resulting in death) /Medical Examiner Due to (or es e consequence of): Physician/Medical Examiner g physician end as the buriel-transit The law requires that the death cartificete be executed Sequantielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Box 68760. Dua to (or es e consequence of): 980 for Division of Vital Records. P.O. signed by t þ Completed page 2 has al or Attending Physician: T s efter deeth. Il Director: After this certificat od in by the tuneral director, p Be 25. Wes case referred to medical exeminer? Hospital: 1 Inpatiant 1 Yes 2 □ No Certification: To 2 ER/Outpetlent 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 1 X Naturei 5 Pending investigation 2 Accident 6 Could not be determined 3 Sulcide the Funeral Direction of the Funeral Direction 4 Homicide Hospital 29a. Certifier (Check only one) 1 29b. Signature end title of certifler O.C.M.E. 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) DAVID R.FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signature State MAY 1 6 1997 ii ta Nyydson-Handells Registrar **DHMH 16 Rav 6/95**

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year Miriam Clopper Coldain MAY 10 1997 5:46P.M. 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 1119 MEADOW LARK DRIVE ARBUTUS BALTIMORE if Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplece (State or Foreign Country) Months Deys 213-22-8129 70 11, AUG. 1926 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Md. Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 1119 Meadow Lark Drive 21227 USA Funeral Rece - Amarican Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puarto Rican, etc.) 11. Meritel Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give No 1 Yes 2 No Specify: white þ Specify: 3 Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Thomas H. Clopper Florence H. Reed 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21227 Joseph B. Colgain - husband 1119 Meadow Lark Drive, Baltimore, Md. 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete Dete ^{5/}13/97 1 XBuriel 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Greenmount Cemetery Hillsboro, Maryland 21. Signatura of Funeral Service Doe 22. Name end Addrass of Facility Gary L. Kaufman Funeral Home at Meadowridge 7250 Washington Blvd., Elkridge, Md. art1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Deeth Arteriosclerotic Cardiovascular Disease Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings avelleble prior to completion of cause of deeth? 24a. Wes en eutopsy INSPECTION 1 Tyes 2 No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28c. Injury et Work? 1 Yes 2 No Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menne stated. 29c. License number 29d. Date signed (Month, Dey, Year)

